

Domestic Homicide Review

Shropshire Safeguarding Community
Partnership

**Report into the death of Ella
December 2023**

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Pen Portrait of Ella

Ella liked singing, gardening, history, arts and crafts, and she loved animals. Ella was born in Liverpool but grew up in Plas Madoc. She moved down south when she was around 19 with a partner. Ella worked as a manager in a restaurant until moving from the south of England to Shropshire. She always wanted to go back to college and eventually university but struggled to after she became pregnant with her daughter. Ella had one child, a daughter. Ella's daughter described her mother as very talented and someone who had been very driven to achieve.

Ella had been married to Bill, but they separated. Ella had mental health needs and also experienced increasing mobility difficulties. When Bill and Ella separated, Ella's daughter became Ella's carer until she left home in 2009. In 2015, Ella entered into a relationship with Sean, and this relationship continued until Ella's death in December 2023.

Ella's daughter said that Ella had lived through adverse childhood experiences and had been sexually abused as a child. Ella's mother had also not been affectionate towards her. Ella's daughter described Ella as being angry about her family and the experiences she had as a child. Into adulthood, Ella continued to have heated exchanges with her mother. Ella had been drinking alcohol for as long as her daughter could remember. Ella attempted to take her own life on a number of occasions by either drinking cleaning fluids, overdosing on medication or slitting her wrists. Ella's daughter felt these incidents were cries for help, but that Ella did not always accept help when offered.

Ella's daughter said that Ella's house used to be spotless. According to Ella's daughter the circumstances and surroundings in which Ella died were a far cry from how she had been in earlier days.

Preface

The Independent Chair and the Panel members of this Domestic Abuse Related Homicide Review (DHR) offer their deepest sympathy to all who have been affected by the death of Ella and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Chair also thanks the Panel members for the professional manner in which they have conducted the Review and the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1. Introduction

- 1.1 Domestic Homicide Reviews came into statute on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Review was commissioned as a domestic homicide review (DHR) under the existing guidance and criteria set out below. It is recognised that the Victim and Prisoners Act 2024 has amended the original legislation to replace DHRs with Domestic Abuse Related Death Reviews (DHRs), which accordingly is the term used throughout this report.

- 1.2 The Domestic Violence, Crime and Victims Act (2004) states that a DHR/ DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
- a) A person to whom she was related or with whom she was or had been in an intimate relationship, or;
 - b) A member of the same household as herself;

With a view to identifying the lessons to be learnt from the death.

- 1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

- 1.4 The Domestic Abuse Act (2021) defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

- 1.5 For the definition to apply, both parties must be aged 16 or over and ‘personally connected’, which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child

- are relatives
- 1.6 Controlling behaviour is defined as, *“A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour”*.
 - 1.7 Coercive behaviour is defined as, *“An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*
 - 1.8 This DHR examines the circumstances leading up to the death of Ella on 18th December 2023.
 - 1.9 All names of individuals in this report are pseudonyms.
 - 1.10 This Review, as commissioned by Shropshire Safeguarding Community Partnership, considers the involvement and actions of the different agencies with Ella and her partner Sean from 1st December 2017 to 19th December 2023. In addition, the Review also examines past events to identify any relevant background or trail of abuse before Ella’s death.

2. Timescales

- 2.1 Twenty-two local agencies were sent an initial scoping form and asked to examine their records to see if they had provided services or support to Ella or Sean, they were also asked to secure their records. Ten agencies were found to have relevant information. An initial scoping meeting was held on 29th January 2024. From this meeting the Key Partners made the recommendation to the Shropshire Safeguarding Community Partnership’s Independent Chair that the criteria had been met for a Joint Safeguarding Adult Review and Domestic Homicide Review. The Independent Chair concurred. From the information provided at the initial scoping meeting there were a further two agencies identified that would be important contributors to the Review. There were some delays in commissioning this DHR. The Community Safety Partnership was initially unable to commission an independent author and an internal author was appointed. The review began but then a decision was made to commission an independent author who continued and completed the review.
- 2.2 The decision to undertake a DHR was made by Shropshire Safeguarding Community Partnership in consultation with local specialists. The Home Office was informed of this decision on 13th March 2024. IMRs were commissioned and agencies were advised to implement any learning arising from these as soon as possible. A Panel meeting to discuss the IMRs was held on 24th June 2024. An Independent Chair and author for the Review was appointed in September 2024.
- 2.3 The terms of reference requested details of contact with Ella or Sean between 1st December 2017 and 19th December 2023, the day after Ella’s death. Agencies were

asked for details of contact with Ella and Sean from December 2017 onwards. It was understood that Ella had suffered head injuries in December 2017 and February 2018 and that these injuries had an enduring negative effect on Ella's health.

- 2.4 This Overview Report and its Executive Summary were presented to Shropshire Adult Statutory Case Review Group, which is responsible for ensuring learning from DHRs is distributed on 15th January 2026. The Report and its Executive Summary were then presented to the Shropshire Community Safety Partnership on 23rd February 2026. The contents of this DHR were then submitted to the Home Office on 9th March 2026.

3. Confidentiality

- 3.1 The findings of this Review are confidential. Information is only available to participating professionals and their line managers until the Review has been approved for publication by the Home Office Quality Assurance Panel.
- 3.2 As recommended within the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews, (2016, Home Office), pseudonyms have been agreed for those involved, to ensure their identities are protected. These pseudonyms were agreed with Ella's family.
- 3.3 The table below shows the age, ethnicity and gender of the victims and perpetrator and their allocated pseudonyms.

	Pseudonym	Age	Ethnicity	Gender
Victim	Ella	53	White British	Female
Victim's partner, the perpetrator of domestic abuse	Sean	54	White British	Male

4. Terms of reference

- 4.1 The following key lines of enquiry were agreed by the DHR panel to guide the Review. *These were discussed with Ella's daughter who felt they covered what was necessary.*
- 4.2 Was your agency aware that there was domestic abuse in Ella and Sean's relationship? How did your agency respond to this and minimise the risk to Ella?
- 4.3 How did your agency respond to incidences of domestic abuse between Ella and Sean? Is there anything that could have been done differently?
- 4.4 When Ella disclosed domestic abuse how did your agency respond to hearing her voice when she said she felt she had no option other than to return?

- 4.5 In February 2018 Ella suffered a traumatic subdural suffered*, what is your understanding about how this occurred?
- 4.6 Was Ella's heightened vulnerability owing to her physical health considered as part of the risk assessment?
- 4.7 Given Ella's stroke and seizures did she have the capacity to make her own decisions about future living arrangements.
- 4.8 How was Sean managing financially after he finished work in November 2022 – was there any evidence of economic abuse?
- 4.9 How did agencies work together to protect and safeguard Ella?
- 4.10 * In the initial stages of this Review, it was believed that Ella had suffered a traumatic subdural haematoma in 2018, but as the Review progressed it became apparent that Ella had suffered a subdural empyema instead. An empyema is caused by an infection rather than by a head injury.

5. **Methodology**

- 5.1 Twenty-two local agencies were sent an initial scoping form and asked to examine their records to identify if they had provided services or support to Ella or Sean. Ten agencies were found to have relevant information. An initial scoping meeting was held on 29th January 2024 and from this meeting the key partners made the recommendation to the Shropshire Safeguarding Community Partnership's Independent Chair that the criteria had been met for a Joint Safeguarding Adult Review and Domestic Abuse Related Death Review. The Independent Chair agreed. From the information provided at the initial scoping meeting there were a further two agencies identified that would be important contributors to the Review.
- 5.2 The key lines of enquiry were drawn up by the original independent chair and author in consultation with and agreed by the panel. A template Individual Management Report was sent to each agency involved with both Ella and Sean. The template asked agencies for a chronology of their involvement as well as to provide responses to these specific key lines of enquiry. Agencies were also asked to identify any individual learning from their exploration of involvement with Ella and Sean.
- 5.3 The Review involved the analysis of each agency's IMR, chronologies of agency contact with Ella and Sean, and questions for professionals. Family members were also interviewed by the original chair.
- 5.4 Individual Management Reports (IMRs) were written by individuals who did not work directly with Ella or Sean, and these were presented to the Review Panel, where there was opportunity for questions to be posed by panel members.

6. Involvement of family

- 6.1 Ella had a daughter from her first marriage. Ella's daughter was being kept informed of the progress of the criminal investigation by a police officer. It was through West Mercia Police that Ella's daughter was notified that a DHR was being undertaken. The chair and author of this Review spoke with Ella's daughter who talked of how her mother's alcohol use and mental health condition had led to a breakdown in their relationship some years prior to Ella's death. This meant that Ella's daughter did not know what had been happening in Ella's life in recent years and was keen for the Review to go ahead. Ella's daughter hoped that this would help her to understand what had led up to her mother's death but also potentially prevent future deaths by identifying learning.
- 6.2 Ella's daughter was provided with details of AAFDA (Advocacy After Fatal Domestic Abuse) and the Home Office information leaflet.
- 6.3 The Chair and Author of this Review spoke with Ella's daughter, and her contributions have been included in this report. Ella's daughter was also invited to meet with the DHR panel.
- 6.4 A copy of the draft report was shared with Ella's daughter prior to submission to the Home Office. She was advised that she could take whatever time she needed to read it and that any comments or suggested amendments would be gratefully received. Ella's Daughter was also offered support from the Shropshire Safeguarding Community Partnerships Development Officer in reading the report.
- 6.5 The Shropshire Safeguarding Community Partnership Business Unit will support Ella's daughter in relation to the publication of this review. They will determine and appropriate date with her and provide her with any support that she requires.

7. Contributors to the Review

- 7.1 **List the agencies and other contributors to the Review and the nature of their contribution.**
- 7.2 The request to complete an initial scoping form revealed that the following organisations had been in contact with Ella or Sean during the period of time under consideration in this DHR:

Shropshire Council Adult Social Care
West Mercia Police
Shropshire Recovery Partnership / With You (alcohol support)
Shropshire Council Housing Options Team
Midlands Partnership University NHS Foundation Trust
GP Practice
Shrewsbury and Telford Hospital NHS Trust (SaTH)

West Midlands Ambulance Service
Shropshire Community Health NHS Trust
Department for Work and Pensions
University Hospitals of the West Midlands (RSUH)
Care Home and care provider

7.3 Care Agency D provides domiciliary and other care services. Accommodation 14 (a care home) is a residential home, which also provides respite and day care services run by Care Agency D.

7.4 Shropshire Recovery Partnership, delivered by With You, provides free and confidential services, without judgement, to adults and young people facing challenges with drugs and alcohol.

8. The Review Panel Members

8.1 The Review Panel members were all independent. None had direct contact with Ella or Sean. The DHR panel, which met four times, consisted of the following members.

Independent Chair and Author	Patrick Hopkinson
Development Officer	Shropshire Safeguarding Community Partnership
Head of Adult Safeguarding	Shropshire and Telford & Wrekin Integrated Care Board
Service Manager for Safeguarding Adults	Shropshire Council Adult Social Care
Detective Inspector	West Mercia Police
Prevention Manager	Shropshire Fire and Rescue Service
Head of Probation	The Probation Service
Service Manager	Shropshire Recovery Partnership
Domestic Abuse Strategic Lead – specialist advisor	Shropshire Council
Senior Housing Options Officer	Shropshire Council Housing Options Team
Head of Safeguarding	Midlands Partnership University NHS Foundation Trust
Named GP for Safeguarding	GP Practice
Head of Adult Safeguarding	Shrewsbury and Telford Hospital NHS Trust
Clinical Safeguarding Officer	West Midlands Ambulance Service
Nurse Specialist Safeguarding Adults	Shropshire Community Health NHS Trust
Head of Safeguarding	Shropshire Community Health NHS Trust
Advanced Customer Support Senior Leader	Department for Work and Pensions
Adult Safeguarding Nurse	University Hospitals of North Midlands NHS Trust

Registered Manager	Care Home and care provider
Principle Social Worker and Service Manager	Shropshire Council Children's Services

9. **Author of the Overview Report**

- 9.1 The Independent Chair, who is also the Author of this Overview Report, is Patrick Hopkinson, an independent adult safeguarding consultant, a Safeguarding Adults Review author and a Chair and author of Domestic Abuse Related Death Reviews.
- 9.2 The Independent Chair is experienced in adult safeguarding and provides training, including on domestic abuse, consultancy and service development services nationwide for the statutory and voluntary sectors. The Independent Chair was the Head of Adult Safeguarding for a London Borough, contributed to regional and national policy development and was the adult social services strategy lead on Violence Against Women and Girls (VAWG). The Independent Chair was a member of a Community Safety Partnership and developed practice and strategic links between domestic abuse services, adult safeguarding and the Metropolitan Police to recognise and respond to domestic abuse experienced by people with mental health needs, learning disabilities and physical disabilities. The Independent Chair has completed the Home Office online Domestic Homicide Review training, hold the DHR Chair's Certificate and is a member of the AAFDA (Action After Fatal Domestic Abuse) network.
- 9.3 The Independent Chair is an Associate of the Local Government Association, and of Partners in Care and of Research in Practice of Adults. Between 1995 and 2019 the Independent Chair lectured, conducted and supervised research at the Institute of Psychiatry, Psychology and Neuroscience, Kings College, London. The Independent Chair is the author of peer-reviewed original research-based journal articles and book chapters on mental health and on adult safeguarding. The Independent Chair is the creator of the IDCAP (International Digital Collaborative Autoethnographical Psychobiography) research method, which enables people from marginalised groups to research their experiences of abuse, neglect and recovery. The independent chair is a Fellow of the Royal Society of Medicine and a Member of the British Psychological Society.
- 9.4 The Independent Chair has no connection with the Community Safety Partnership, and agencies involved in this Review other than in chairing Safeguarding Adults Reviews and Domestic Abuse Related Death Reviews.

10. **Parallel Reviews**

- 10.1 A police investigation was concluded with No Further Action. There has been no Coroner's Inquest since Ella died of natural causes.

11. Equality and Diversity

- 11.1 It is important to consider the individual needs of Ella and Sean within the nine protected characteristics, as defined in Section 4 of the Equality Act 2010. This includes examining barriers to accessing services in addition to wider considerations of service delivery.
- 11.2 Section 149 of the Equality Act (2010) introduced a public sector duty, which is incumbent upon all organisations participating in this Review, to:
- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
 - Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- 11.3 The Review gave due consideration to all ten of the protected characteristics under the Equality Act, which are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
- 11.4 The Review also gave due consideration to gender and how women are disproportionately affected by domestic abuse.
- 11.5 Section 6 of the Act defines 'disability' as:
- (1) A person (P) has a disability if –
- (a) P has a physical or mental impairment, and
- (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities
- 11.6 Ella met criteria (a) Ella had multiple complex physical and mental health needs. It appears that Ella met (b) as she required a carer.
- 11.7 Ella was a 53-year-old White British woman whose first language was English. Ella was a Roman Catholic. Ella had multiple mental health needs as well as physical health needs. Ella had one child.
- 11.8 This Review is of the neglect and death of a woman, Ella. Women's Aid state that domestic abuse, perpetrated by men against women, is a distinct phenomenon

rooted in women's unequal status in society and oppressive social constructions of gender and family¹

11.9 During the time covered by this Review Sean was a 54-year-old White British man. It is not known if Sean has any overt religious beliefs or affiliations. Sean is known to have had mental health needs. Domestic abuse is frequently regarded as gendered: women are more likely to be the victims of domestic violence and abuse than men are, men are more likely to be the perpetrators of domestic abuse than women are.

11.10 **Ella's physical and mental health needs and alcohol dependency**

11.11 According to Public Health England (2015), people with physical disabilities, "...experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people". People with disabilities, "...may also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers". Ella had a weakness in the left side of her body which led to increasing mobility difficulties and required the use of a quad stick. In 2018 Ella suffered fractures to her upper arm and subsequently her wrist, and in 2019 Ella suffered another fracture to her wrist (it is not clear if it was the same wrist). From 2019 Sean became Ella's carer, on whom she became increasingly dependent.

11.12 Public Health England (2015) also highlights that people with disabilities, "are often in particularly vulnerable circumstances that may reduce their ability to defend themselves, or to recognise, report and escape abuse". People with disabilities may also be socially isolated, by mobility needs, stigma and discrimination and may rely on others to help them to meet their wellbeing, health and social care needs. These factors can make it even more difficult to leave an abusive situation. Public Health England (2015) recognises that, not only do people with disabilities, "...experience higher rates of domestic abuse, they also experience more barriers to accessing support, such as health and social care services and domestic abuse services". As well as being isolated because of mobility difficulties, Ella also experienced agoraphobia which may have increased her sense of isolation.

11.13 Ella had taken intentional overdoses of prescription medication on a number of occasions dating back to at least 2004, when Ella was 34 years old. She was treated for depression and according to GP records had several informal admissions to a mental health unit in 2004 and 2007. Ella may have experienced emotional loss and trauma when her daughter decided to leave home at the age of 16 years old in 2009, although this is not specially noted in records. However, Ella's mental health needs may have increased her risk of experiencing domestic abuse, restricted her opportunities to leave an abusive relationship and exacerbated barriers to disclosure. They may also have provided health professionals with satisfactorily compelling explanations for Ella's presentation to services.

¹ (Women's Aid Domestic abuse is a gendered crime, n.d.)

- 11.14 A great deal of research has been conducted on the links between domestic abuse and mental health needs. According to SafeLives (2019), *Mental health problems are a common consequence of experiencing domestic abuse, both for adults and children. And, having mental health issues can render a person more vulnerable to abuse [...] Despite these strong associations, domestic abuse is often going undetected within mental health services, and domestic abuse services are not always able to support people with mental health problems.*
- 11.15 Ella was also alcohol dependent. Ella's daughter could not remember a time when Ella was not drinking. There were various reports of Ella (and Sean) being intoxicated, and of falls being attributed to alcohol. Ella stopped drinking in 2019, but it appears she started drinking again in 2021. Ella experienced many seizures which medical staff thought were likely due to alcohol withdrawal. There was a concern that Ella was a repeat victim of domestic abuse, in which alcohol dependence was both a consequence and a cause. West Mercia Police noted that arguments between Ella and Sean often occurred when they had both been drinking alcohol.
- 11.16 It is possible that Ella's physical and mental health needs and alcohol dependency may have contributed to or have increased the risk of domestic violence and abuse and might have decreased awareness and recognition of it whilst at the same time increasing barriers to receiving support.
- 11.17 The intersection of domestic abuse, mental health issues, and alcohol use creates unique challenges that can make accessing services difficult. Victims of domestic abuse often face systemic barriers, internalised stigma and distrust of services, affecting both their ability and willingness to seek help.
- 11.18 Services may have limited resources and there could be waiting times for support, added to this there can also be strict eligibility criteria which could prevent access. However, there is no suggestion that Ella struggled to access alcohol support services or that there was a wait for this service.
- 11.19 **Sean's mental health needs**
- 11.20 In a consultation with his GP in 2015 Sean mentioned multiple bereavements including his father in 2014 and an aunt recently. At this stage Sean had met Ella, but they had fallen out. Sean told his GP that he was feeling stressed and having depressive thoughts, but that he was not suicidal. Subsequently Sean had some appointments with Cruse (Bereavement Support).
- 11.21 Mental health issues are never the cause of domestic abuse. For victims, mental health problems can create additional vulnerabilities that people perpetrating domestic abuse may seek to exploit, such as threats of institutionalisation, withholding medication and threats to have children taken away. Where perpetrators have mental health needs, they may use these as a way to excuse the abuse they are perpetrating.

- 11.22 Published international research indicates a higher prevalence of mental health needs amongst perpetrators of domestic abuse compared to non-abusive individuals (Oriel & Fleming, 1998) (Shorey, et al., 2012) (Askeland & Heir, 2014) (Okuda, et al., 2015). Some of this research considers DHRs, which also reflect high levels of mental health needs for perpetrators (Bridger, et al., 2017) (Dawson & Piscitelli, 2017) (Oram, et al., 2013). People with mental health needs are more likely to be victims than perpetrators of abuse and are at increased risk from perpetrators (Trevillion et al, 2013).
- 11.23 **Repeating patterns of abuse and disclosure of abuse**
- 11.24 Ella had been abused as a child and was known to have been in an abusive relationship immediately before she met Sean. Research suggests that people who have experienced domestic abuse are at higher risk of entering another abusive relationship. Some victims of domestic abuse may develop emotional attachments to abusive behaviours, known as trauma bonding (Effiong et al, 2022) and learned relationship dynamics can lead to subconsciously seeking out familiar relationship patterns, even when they are harmful (Anderberg et al, 2018). In addition, perpetrators of domestic abuse may target individuals with past trauma because they are more vulnerable to manipulation. Without a strong support system, victims of domestic abuse may struggle to break the cycle of abuse. There is no indication that Ella specifically sought to trauma bond, or that she subconsciously sought out familiar abusive relationship patterns. Ella's experience of abuse as a child, and the barriers that prevented her from escaping abuse, may made it even more difficult for Ella to have overcome barriers when facing abuse as an adult.
- 11.25 Research indicates that mental health practitioners are not always equipped to enquire about, and respond to, domestic abuse. Currently, it is estimated that only 10-30% of domestic abuse cases are identified by mental health services (Greenfield et al., 2025; Trevillion, et al., 2016). The reasons for this include:
- Low levels of enquiry
 - Lack of training
 - Treating symptoms rather than causes
- 11.26 There is evidence that victims of domestic abuse are most likely to disclose abuse to their informal social network, including friends (for example, Sylaska and Edwards, 2020). Victims of domestic abuse are, however, most likely to be in contact with and to disclose abuse to health services than other services (Heron and Eisma, 2021). These include the police or specialist domestic abuse services, and this likelihood of disclosure of abuse to health services is increased when a victim has mental health needs.
- 11.27 All of this means that people receiving informal care from family or friends, and their carers themselves are less likely to disclose domestic abuse. Consequently, it is important for adult safeguarding professionals to identify and enquire about domestic abuse and for domestic abuse services to work with safeguarding

professionals to ensure that care and support needs continue to be met whilst a victim receives specialist domestic abuse support (Local Government Association, 2015).

- 11.28 In summary, Ella may have faced several barriers to recognising, and reporting, domestic abuse and coercion and control in her life as a result of her gender, mental health needs, substance dependency, care needs and relationships. These barriers may have made it especially difficult for Ella to make disclosures about domestic abuse. This highlights the need to include routine enquiry about domestic abuse in contacts with people who, evidence suggests, are unlikely to disclose, or to exhibit obvious signs of, domestic abuse themselves.
- 11.29 There is no evidence that Ella or Sean were directly or indirectly discriminated against by any agency based on the nine protected characteristics under the Equality Act 2010. It is likely, however, that Ella and Sean's mental health difficulties and substance use might have increased the risk of domestic violence and abuse between them and might have decreased awareness and recognition of it by agencies, whilst at the same time increasing barriers to receiving support.
- 11.30 The responses to domestic abuse tend to use the model of separation between victim and perpetrator and the identification of the exercise of coercion and control, even if there is growing attention to interventions to support both victims and perpetrators (for example <https://hamptontrust.org.uk/why-we-need-to-engage-with-domestic-abuse-perpetrators/>). Despite this, these operating models can struggle to work with people who are both victims and perpetrators of domestic abuse.
- 11.31 **Housing instability and homelessness**
- 11.32 Ella experienced considerable housing instability. During the scoping period for this DHR, Ella lived in at least thirteen different addresses. These included two houses where Sean was the primary occupant; three hotels and one pub; three care homes, one shared accommodation and a time when Ella was at no-fixed abode. These were in addition to five relatively long admissions to acute hospitals.
- 11.33 There is substantial, as well as intuitive, evidence that the well-being of both individuals and families is substantially affected when the need for adequate housing is not met. According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, adequate housing consists of legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc.); cultural adequacy; and affordability. It would appear that the places that Ella lived in rarely met these criteria. Despite often having a roof over her head, Ella did not have secure tenure when in temporary accommodation, hotels or care homes.
- 11.34 Ella was in intermittent contact with housing services. There is a strong interrelationship between mental health and homelessness, such that housing can be considered to be "foundational" for good mental health and wellbeing (Padgett,

2020). Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their chaotic and dangerous behaviours are unlikely to be successful.

- 11.35 Zhao (2022) found that the three leading causes of homelessness in the United States were substance abuse, domestic violence, and mental illness. These problems lead to the initial homelessness, and in turn, homelessness further exacerbates them. Circumstances may be different in the United Kingdom, but this pattern has face validity and Ella experienced all three factors of alcohol dependence, domestic abuse and mental health needs.
- 11.36 Homelessness is also often combined with other problems in living. Multiple Exclusion Homelessness is the term used to describe people who have been homeless (including the experience of temporary, unsuitable accommodation as well as sleeping rough) and who have also experienced one or more of the following additional domains of social exclusion:
 - 11.37 Institutional care (prison, local authority care, psychiatric hospitals or wards);
 - 11.38 substance misuse (drug problems, alcohol problems, abuse of solvents, glue. or gas); or
 - 11.39 Participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)
- 11.40 People who meet this definition are likely to be homeless for longer, have escalating health and care needs and have a reduced life expectancy compared with other homeless people who do not have multiple exclusions.
- 11.41 Given what is known of Ella's background and life experiences (admissions to mental health units, substance misuse, temporary and unsuitable accommodation and living in a tent) it would seem that she met the definition of Multiple Exclusion Homelessness.
- 11.42 Housing is also included in the Wellbeing Principle, set out in section 1 of the Care Act 2014, and the provision of suitable accommodation should be considered when making decisions about care and support needs (Ch.15 of the Care Act statutory guidance). Meeting a housing need, however, does not mean that care needs are met (s.23, Care Act 2014).
- 11.43 In terms of addressing homelessness, the Homelessness Reduction Act 2017 requires that local authorities must offer early intervention and prevention to avoid homelessness, must assess housing need, offer advice and information, work with other agencies and develop personalised housing plans.
- 11.44 In addition to homelessness and housing instability, between 2012 and 2020, Ella was registered at five different GP practices.

- 11.45 From July 2012 Ella was registered with GP Surgery A.
- 11.46 From 15th November 2018 Ella was registered with GP Surgery B.
- 11.47 From 13th December 2018 Ella was registered with GP Surgery C.
- 11.48 From July 2019 Ella was registered at GP Surgery D.
- 11.49 From 12th March 2020 Ella was registered with GP Surgery E.
- 11.50 This demonstrates one of the consequences of homelessness and housing instability on consistent access to primary health care. All five GP surgeries were within the Shropshire area, however, frequent changes of GP can lead to inconsistent and fragmented care provision, especially for chronic health conditions. It can also mean that the same information must be provided repeatedly by patients to their GP. Additionally, GP surgeries may lack familiarity with their transient patients (<https://www.health.org.uk/reports-and-analysis/briefings/measuring-continuity-of-care-in-general-practice#:~:text=More%20GP%20visits%20often%20mean,have%20a%20lower%20UPC%20index>).
- 11.51 However, Ella often voluntarily registered at a new GP surgery, presumably because it was closer to where she was living. Ella need not have done this and could have chosen to remain with GP Surgery A. This is a practice that is advised when someone moves to temporary accommodation. Despite this, Ella may not have considered all her moves to have been temporary. Ella's moves seem to have been prompted by incident rather than intention.
- 11.52 **Age**
- 11.53 Ella was 53 years old. The Office for National Statistics data for 2024 showed that people aged 16 to 19 years are more likely to report being a victim of domestic abuse than all other ages are and that 8.7% of people in this age group said that they had experienced domestic abuse (ONS, 2024). For comparison, people over the age of 75 years are the least likely to report being a victim of domestic abuse (2.1%). People aged 45 to 54 years are the fourth least likely age group to report the experience of domestic abuse (4.8%).
- 11.54 **Marital status**
- 11.55 Ella was divorced from her husband, Bill and, at the time of her death, Ella and Sean were cohabiting. ONS (2024) figures show that people who are single (7.6%) and cohabiting (5.1%) are between two and three times more likely to experience domestic abuse than people who are widowed or married. For comparison, people who are widowed are the least likely to experience domestic abuse (2.4%). Those

who are married or are in a civil partnership are the second most least likely to experience domestic abuse (2.5%).

11.56 Ella's Ex-husband, daughter and Sean as carers

11.57 Section 10 Care Act 2014 provides a legal definition of a carer as, "an adult who provides or intends to provide care for another adult". This excludes people who are employed to do this.

11.58 According to the [NHS](#): *A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.*

11.59 On 29th June 2012, Ella told her GP that her husband had been her main carer, but as they were going through a divorce her daughter had become her main carer and her daughter "safeguarded" her tablets. Ella had experienced poor mental health for some years and had prescription medication, on which she had intentionally overdosed on several occasions.

11.60 Sean was noted by Adult Social Care (ASC) as Ella's carer from March 2019. Domestic abuse in caring relationships can be difficult to identify. When harm is *intentional*, this is likely to be domestic abuse, and perpetrators of domestic abuse towards people with care and support needs will have the same motivations for control as in any other domestic abuse situation. In addition, carers who unintentionally or intentionally harm or neglect the adult they are support, often:

- have unmet or unrecognised needs of their own, including health needs
- are themselves vulnerable
- have little insight or understanding of the vulnerable person's condition or needs
- are unwillingly to change their lifestyle
- are not receiving practical or emotional support from other family members
- are feeling emotionally and socially isolated, undervalued or stigmatised
- have other responsibilities, such as family or work
- have no personal or private space, or life outside the caring environment
- have frequently requested help but problems have not been solved
- are being abused by the vulnerable person and/or
- feel unappreciated by the vulnerable person or exploited by relatives or services (LGA and ADASS, 2022).

11.61 These factors may indicate an increased risk that a person may be abused by their family carer and so should be considered in, for example, s10 Carer's Assessments and in s9 care needs assessments under the Care Act 2014 and in domestic abuse and mental health needs assessments. Regardless of whether harm caused by a carer is intentional or not, the impact on the individual affected by the carer's actions, or lack of action, must remain central, and it is important that the nature of the risk posed is understood.

11.62 The services to support people experiencing domestic abuse and to safeguarding adults have developed into separate professional fields. This can lead to lack of recognition of domestic abuse when ASC concerns are raised and to possible perceptions by victims of domestic abuse who have care and support needs that specialist domestic abuse services are inaccessible. Perpetrators of domestic abuse who are carers may deliberately emphasise and reinforce dependency as a way of asserting and maintaining control. Research also shows that people dependent on their abuser for care may be more likely to blame themselves or their care needs for the abuse. All of this means they are less likely to disclose domestic abuse. Consequently, it is important for adult safeguarding professionals to identify and enquire about domestic abuse and for domestic abuse services to work with safeguarding professionals, ensuring care and support needs continue to be met whilst a victim receives specialist domestic abuse support (Local Government Association, 2015).

11.63 The Chair of this DHR recognises the impact that the contents of this Review, some of the terminology used and concepts explored may have on Ella and Sean's family and friends. As with all DHRs, this Review considers a family tragedy and focuses on the actions of different agencies in response to risk factors. By doing so it in no way is intended to minimise the personal loss suffered by family and friends.

12. Dissemination

12.1 The following people were provided with a copy of the DHR report

- Family of Ella
- Corporate Director Population, Wellbeing and Neighbourhoods (Shropshire Council)
- Leader of the Council (Portfolio Holder for Community Safety)
- Local Policing Commander, Superintendent, West Mercia Police
- Chief Nursing Officer, Integrated Care Board
- Head of Probation
- Prevention and Protection Manager, Shropshire Fire and Rescue
- Chair of Tackling Drug and Alcohol Partnership Board
- Chair of Domestic Abuse Partnership Board
- Nicole Jacob, Domestic Abuse Commissioner
- John Campion, Police and Crime Commissioner

13. Background information (the facts)

13.1 Where the victim and perpetrator lived

13.2 Apart from instances where Ella and Sean's accommodation was unknown (of no fixed abode) all of Ella and Sean's accommodation during the scoping period for this Review was within Shropshire.

TIME	LOCATION		COMMENTS
-2017	Accommodation 1 (private address)	Ella	At the start of the scoping period Ella lived here.
-2017	Accommodation 2 (private address)	Sean	Ella spent some time at Sean's house; she moved in with her cats. Ella was admitted to SaTH on 28 th April 2017
May 2017	Accommodation 3 (a hotel)	Sean	Uncertain length of stay
31 st May 2017	Accommodation 4 (private address)	Sean	Temporary accommodation, after notice had been served on Sean's uninhabitable property.
13 th June 2017	Accommodation 5, shared accommodation placement	Ella	Ella was discharged from SaTH on 13 th June to this placement. However, Ella spent most of her time at Accommodation 4. Ella was admitted to SaTH on 3 rd February 2018, transferred to Stoke Hospital on 5 th February, transferred back to SaTH on 28 th February. The SaTH discharge letter states that Ella was discharged from Princess Royal Hospital to "home or usual place of residence" and does not state when.
March/April 2018		Sean	Sean was evicted from Accommodation 4.
5 th April to 13 th 2018	Accommodation 6 (emergency hotel accommodation)	Ella and Sean	Accommodation 6 asked Ella and Sean to leave

From 13 th April to 3 rd December* 2018	Accommodation 7 (No Fixed Abode)	Ella and Sean*	Housing Options Team (Housing) considered it had discharged its duty to provide emergency accommodation
22 nd April to 29 th April 2018	Accommodation 8 (a hotel)	Ella and Sean	Accommodation 8 (a hotel) asked Ella and Sean to leave.
5 th July 2018	It was thought that Ella and Sean had been staying at a pub. Ella told SaTH that she had been living alone in a tent.	Ella	Accommodation 9 (no fixed abode)
18 th September 2018	Royal Shrewsbury Hospital	Ella	Ella was admitted to SaTH on 18 th September 2018..
12 th November 2018	Discharged from SaTH to Accommodation 10 (a care home)	Ella	
3 rd December 2018 to 4 th February 2019	Accommodation 11 (an adapted bungalow)	Ella and Sean	Ella was given notice to leave.
4 th February to 15 th June 2019	Accommodation 3 (a hotel)	Ella and Sean	Ella was admitted to acute hospital on 24 th May 2019, she was discharged to a Community Hospital on 31 st May 2019 and on 15 th June 2019 Ella was discharged to Accommodation 12 (a care home)
15 th June 2019 to 7 th March 2020	Accommodation 12 (a care home)	Ella	
7 th March 2020 on wards	Accommodation 13 (a private address)	Ella initially.	Sean stayed with Ella more as time went on and latterly lived with her full time. On 25 th April 2022 Ella was admitted to SaTH and discharged on 6 th May 2022 to a Community Hospital until 9 th June 2022

9 th June 2022	Accommodation 14 (a care home)	Ella	
22 nd August 2022 onwards	Accommodation 13 (a private address)	Ella and Sean	

13.3 **Members of Ella's family and household**

13.4 Ella had several intimate partner relationships, including, in chronological order, with her husband, Bill, with her partner, Gareth, and with her partner, Sean. Gareth was recorded as being Ella's ex-partner in 2014. Ella and Sean had been intimate partners since 2015. Ella and Sean were not married or in a civil partnership and had no children together. Ella had one child, a daughter, from a previous relationship. Bill is the stepfather of Ella's daughter. Relations between Ella and her daughter had been strained, as Ella was often critical of her daughter, and Ella's daughter left home in 2009.

14. **Chronology: The events on the day of Ella's death**

14.1 On 18th December 2023 Sean called for an ambulance to their home as Ella was lying on the floor. Sean reported that Ella had fallen out of bed two days earlier and that he had left her there. The ambulance crew found Ella living in squalid conditions and described Ella as being very poorly, barely conscious, and with what appeared to be wound marks on the back of her knees and her buttocks. Ella was wearing a top and one hospital sock but nothing else. The crew took Ella to SaTH as an emergency because they believed her condition to be critical. The ambulance crew then contacted West Mercia Police to report its concerns about Ella. The police telephoned and later visited the hospital to understand more about Ella's condition. Following this the police attended Sean's home address. Given the condition of the property and the apparent neglect of Ella and her needs the police arrested Sean on suspicion of ill treatment and neglect of Ella.

14.2 Ella died in hospital later that day.

14.3 **Details of the post-mortem**

14.4 A post-mortem was conducted on 20th December 2023. Wounds to Ella's buttocks and legs were found not to be cuts or slash marks (as first thought) but were consistent with pressure from Ella lying on the floor. A pathologist examined Ella's body and found an old head injury and rib fractures.

14.5 **Finding of the Coroner's Inquest**

14.6 There has been no Coroner's Inquest since Ella died of natural causes.

- 14.7 What is known about Ella and Sean?**
- 14.8 Whilst the terms of reference for this Review focused the analysis of agency involvement with Ella and Sean on the period between 1st December 2017 and 19th December 2023, events and information before this were also analysed if they had relevance to later events or showed any indicators of potential domestic abuse.
- 14.9 This analysis is framed within a context in which one in four women will be the victim of domestic violence and abuse and coercion and control during their lifetime. Domestic abuse and coercive control should be suspected and explored if any risk factors for it are present and should not be considered to be exceptions. The Chair and author of this DHR understands that Ella's family members may find this distressing, but this form of analysis is necessary to support services to make changes to their practice to prevent similar tragedies from occurring.
- 14.10 Views of family**
- 14.11 The DHR author and board Development Officer spoke to Ella's daughter, who described her mother as very talented. Ella liked singing, gardening, history, arts and crafts, and she loved animals. Ella worked as a manager in a restaurant until moving from the south of England to Shropshire. Ella's daughter recalled that her mother had been very driven to achieve for the first ten years of Ella's daughter's life.
- 14.12 However, Ella's daughter said that Ella had lived through adverse childhood experiences and had been sexually abused as a child. Ella's mother had also not been affectionate towards her. Ella's daughter described Ella as being bitter and resentful about her family and the experiences she had as a child. Into adulthood Ella continued to have heated exchanges with her mother. Ella had been drinking alcohol for as long as her daughter could remember. Ella had mental health needs and attempted to take her own life on a number of occasions by either drinking cleaning fluids, overdosing on medication or slitting her wrists. Ella's daughter felt these incidents were cries for help, but that Ella did not always accept help when offered. When Bill and Ella separated, Ella's daughter became Ella's carer until she left home. Ella was often critical of her daughter, which contributed to relationship difficulties between them.
- 14.13 Ella's daughter understood that Sean was caring towards Ella and that he had supported Ella financially. Ella never mentioned any abuse by Sean to her daughter.
- 14.14 Ella's daughter said that Ella's house used to be spotless. According to Ella's daughter the circumstances and surroundings in which Ella died were a far cry from how she had been in earlier days.
- 14.15 Chronology of agency involvement with Ella and Sean**
- 14.16 Events prior to Ella meeting Sean**

- 14.17 Ella had a history of depression and overdoses. She had been the victim and suspect in several incidents that came to the attention of West Mercia police. In one case Ella had been violent towards her husband, Bill, but no charges were brought. Ella had twice been admitted to a mental health hospital. Ella suffered from agoraphobia and a psychiatric report stated that she used alcohol as a coping mechanism. Ella was also intermittently under the care of the community mental health team, but the team found it difficult to engage with her. Ella missed appointments which were attributed to her agoraphobia.
- 14.18 Ella's daughter helped her mother dress and undress when Ella was unable to do so and Ella's daughter was often up in the night supporting Ella, when Ella was crying. Ella's daughter spoke to a counsellor and was supported by "Young Carers" at the Carers Centre. Ella's daughter found this helpful as it gave her some respite from home. However, Ella was resentful that her daughter had spoken to others as she believed they would regard her as "bad" mother.
- 14.19 In 2014 Gareth, Ella's partner at the time (not husband), caused criminal damage to her home and set her garden shed on fire.
- 14.20 In 2015 Gareth was arrested for assaulting Ella. Gareth made contact with Ella, which breached the police bail conditions. A risk management plan (RMP) was created by West Mercia Police on 30th July 2015 for Ella and Gareth, her then ex-partner. West Mercia Police closed the RMP on 17th January 2016 as several months had elapsed without recorded incidents.
- 14.21 **Events after Ella met Sean**
- 14.22 It appears that Ella and Sean's relationship began in 2015.
- 14.23 On 28th November 2016, Royal Shrewsbury Hospital SaTH raised a MARAC referral when Ella disclosed that she had been emotionally abused by Sean. Ella said she was scared of Sean when he lost his temper, that he was controlling and that she felt isolated. In response on 1st December 2016 a Domestic Abuse Risk Management Plan (RMP) was created for Ella and Sean to monitor their relationship, check on their welfare and offer support to them both. The police logged all contact they had with Ella and Sean on the RMP.
- 14.24 On 5th December 2016 ASC notified Ella's GP that Ella had alcohol problems and that she had been in an abusive relationship in the past. Ella was living in Accommodation 2 in a house that was cold and lacked cooking facilities. It was thought the house was that of her partner Sean.
- 14.25 **Year 2017**
- 14.26 At the beginning of 2017 Ella was living at Accommodation 1 and she was registered with GP surgery A.

- 14.27 On 3rd January 2017 a Police Officer and an Environmental Health Officer made a welfare visit to Sean's home at Accommodation 2 about the conditions he was living in. There was no reply, but the Environmental Health Officer was able to take some photographs of the property.
- 14.28 On 7th January 2017 at the request of the occupier, police officers attended a different address from which they removed Sean. Both Sean and Ella had been at the address drinking cider and Sean was subsequently arrested for being drunk and disorderly.
- 14.29 On 13th January 2017 police officers made a RMP visit to Ella. Ella said that she was upset that an acquaintance, Wayne, who was Ella's neighbour, would not let Sean into Wayne's home. Ella had no means for police officers to contact her because she did not have a mobile telephone. Later that day police officers visited Ella again to establish a means of contacting her. Wayne's telephone number was given to police as a means of contacting Ella.
- 14.30 On 8th February 2017, police officers attended Accommodation 2, but received no answer, even though the officers could hear Sean and Ella within the property. Police officers noted that there very little glass left within the window frames of Sean's home.
- 14.31 On 20th February 2017, police officers attended Accommodation 2 for a welfare check and spoke to Ella outside. This is correct practice when an adult is on a Risk Management Plan. Ella wanted the police officers to take her to buy alcohol, which they declined to do. Ella confirmed to police officers that she was living between Sean and Wayne's addresses. It appears that Ella had moved in with Sean and had brought her cats with her. Ella told the attending police officers that she did not want any further visits and that she did not need help or support. It is not clear whether the police officers made attempts to explain that their visits were part of the risk management plan or to persuade Ella to accept further visits.
- 14.32 On 21st February 2017 the police recorded a vulnerable adult incident after Ella was found lying in the road outside Accommodation 2. The Harm Assessment Unit recorded that the incident did not show that Ella had met the criteria of a vulnerable adult requiring a referral to ASC. Ella said she was cold and lonely and was taken to one of her friends. It was recorded that the incident had arisen due to alcohol and that Ella "had the capacity to choose and accept the risks associated with her lifestyle choice".
- 14.33 On 8th March 2017 Sean was issued with a prohibition notice which stipulated that he must not live in his house because it was not fit for human habitation. Sean owned the home jointly with his sister and he told practitioners that he wished to sell the house.

- 14.34 On 14th March 2017 Ella was referred by Housing to ASC since it was thought Sean was trying to control Ella, who did not seem well and was self-neglecting and lived in an unsuitable property with Sean.
- 14.35 Consequently, on 20th March 2017 ASC opened a Section 42 Care Act 2014 Adult Safeguarding enquiry. ASC and West Mercia Police planned to make weekly joint visits to Ella and Sean.
- 14.36 On 3rd April 2017 police officers attended Accommodation 2. There was a light on in the property but no answer at the door. Officers spoke to a neighbour who confirmed that Sean and Ella had been quieter since Sean had been served with a prohibition notice, but they were still living there. The police advised the Environmental Health team.
- 14.37 On 5th April 2017 police officers and an ASC member visited Sean's home. They knocked on the door and Ella answered verbally from inside the house but refused to come outside to speak.
- 14.38 On 12th April 2017 police officers and an ASC member attended Sean's address. Neighbours said that it had been quiet at the address for several days.
- 14.39 On 16th April 2017 a report was made to the police that Ella had used a set of keys, that she had permission to hold, to enter a property of her ex-partner and remove a mobile telephone. No action was taken due to a lack of evidence. It is not clear if this was related to events on 13th January 2017 when Ella told the police that she did not have access to a mobile telephone.
- 14.40 On 21st April 2017 police officers and ASC made a RMP visit to Sean's home. There was no answer at the door and Sean's car was not there. Police confirmed Sean's working days with his employer so that they could arrange to speak to him at home.
- 14.41 On 28th April 2017, a member of ASC, a Housing Officer and a police officer made a joint visit to Sean's home in the hope of talking with both Ella and Sean, as they had been unable to speak to them on several previous occasions. Sean denied that Ella was at home, but then said she was unwell upstairs. The ASC practitioner persuaded Sean to allow her to see Ella. The practitioner found Ella in bed, clearly unwell. Ella had difficulty communicating, was very jaundiced and stated that she had stomach pains. Sean stated that Ella had not drunk alcohol or eaten for the last few days. Ella was taken to SaTH by West Midlands Ambulance Service (WMAS). The ambulance crew noted, and took photographs of, the conditions Sean and Ella were living in. Sean confirmed to the police that the house was going to be auctioned in June 2017.
- 14.42 West Mercia Police notified the Harm Assessment Unit, which reviewed the incident. Since Ella was left in the care of health care professionals and ASC were already aware of the incident, no referrals were made to other agencies.

- 14.43 Reflecting on the events of 28th April 2017 West Mercia Police stated that it could have made a referral for alcohol support for Sean and Ella, had they consented to this. The Police Officer recorded the event as a vulnerable adult incident and recorded details of the uninhabitable living conditions in Accommodation 2. This enabled the police to check if conditions worsened in the future.
- 14.44 In hospital Ella was treated for acute hepatitis (decompensated liver disease) with hepatic encephalopathy (changes in the brain due to liver disease), and community acquired pneumonia with pulmonary oedema. The ward consultant assessed Ella's mental capacity, and which concluded that Ella did not have capacity (It is not clear what decision Ella did not have capacity to make) to make decisions in her best interests.
- 14.45 According to ASC records, on 29th April 2017 Ella disclosed to ward staff that she did not want Sean to visit (which the ward actioned) and alleged that she had been kidnapped and raped by Sean. However, according to police records Ella alleged that she had been kidnapped and raped by three men. SaTH has no record that Ella made any rape allegations whilst at SaTH. Consequently, it is difficult to ascertain whether Ella had told hospital staff that she had been raped by three men or by Sean only.
- 14.46 Police officers visited Ella, in hospital on 29th April 2017 but she could hardly speak and made no further disclosures. With Ella's health taking priority, police officers decided to return on another date when more information might be obtained from Ella.
- 14.47 On 30th April 2017 police officers from the Domestic Abuse Unit (DAU) visited Ella in hospital. Ella said that she feared Sean and that he was very controlling. Sean had hit and attempted to hit and sexually assault Ella and would not allow her to see her friend. Ella told the police officers that she wanted to make a complaint about Sean's behaviour towards her. Police Officers checked for injuries to Ella with the assistance of hospital staff. There were bruises evident on Ella's arms, but hospital staff explained that these were from them trying to take blood and Ella's complaints of back pain may have been due to her liver. Police Officers decided to return at a later date to give Ella the opportunity to rest and receive further treatment before she made a decision about making a complaint about Sean.
- 14.48 On 2nd May 2017 a police officer visited Ella in hospital and completed a Domestic Abuse Stalking Harassment (DASH) risk assessment. Ella was assessed as at medium risk. Ella said that when at home she did not see anyone, was in the house all day, and that she felt depressed and had attempted to leave Sean on several occasions during the year. The police officer noted that Ella had been assessed that day by a doctor to not have mental capacity (what decision Ella lacked the capacity to make is not clear). The police officer recognised that a further DASH assessment could be completed when Ella was more lucid. A domestic violence protection notice (DVPN) was considered, but due to Ella being "safeguarded" by the hospital ward by refusing entry to Sean it was felt that one was not necessary at this time.

- 14.49 Separately on 2nd May 2017, police officers, Housing and ASCS visited Sean, who completed a housing application, and arranged emergency accommodation for him.
- 14.50 On 3rd May 2017 a West Mercia Police supervisor commented on Ella's crime report that Ella's "lifestyle choice had a significant impact on her health and mental health" and that she "lacked mental capacity to act in her best interests". The hospital advised the police that Ella would have regular care and support needs for the rest of her life.
- 14.51 On 16th May 2017 Sean's GP told ASC that Sean and Ella were self-neglecting, and Sean was living in temporary accommodation (Accommodation 3) while Ella was ill in hospital (SaTH). Sean's GP considered that alcohol use was a factor along with Sean feeling depressed. On the same day Sean told his GP that he blamed his self-neglect on the house he was in and that he was looking forward to moving back to Accommodation 2. Sean told his GP that he had reduced his alcohol intake but was vague about the amount of alcohol and food consumed.
- 14.52 Sean moved into temporary accommodation at Accommodation 4, on 31st May 2017.
- 14.53 On the 25th May 2017 SaTH referred Ella to the RAID (Rapid Assessment, Interface and Discharge) team to "consider "her mental health needs and to query if Ella had Korsakoff's syndrome (a chronic memory disorder caused by severe thiamine deficiency and often associated with alcohol misuse). SaTH also notified the RAID team that Ella had made a disclosure of rape by Sean. The RAID team consultant found no evidence to indicate a diagnosis of Korsakoff's syndrome, but that Ella was in an acute "emotional situation" which would resolve itself and Ella would regain capacity. Ella told the RAID consultant that she had withdrawn her statement about having been raped but stated that Sean had been keeping her drunk so she would not leave him and had touched her inappropriately. This conversation took place on the same day as Ella's interview with police officers (2nd June 2017).
- 14.54 On 2nd June 2017 police officers attended the hospital again to speak with Ella, who could not recall her conversation with police officers on 29th April 2017 and was shocked when told that she had reported a rape. Ella explained that she had been sexually abused as a child and had also been raped as an adult before she had met Sean but had not reported it at the time. Ella did not want further police involvement and would not provide any further information. When asked about her allegation of being kidnapped Ella stated that she did not have the physical means to get up and leave. Ella said that Sean had been playing mind games and due to her mental state at the time she believed him. Ella said that her relationship with Sean was not violent despite both having previously been arrested for assaulting each other in 2016. Ella confirmed that Sean had not sexually assaulted her.
- 14.55 Ella told police officers that she had made bad choices with relationships. The police officers explained the Freedom Programme (a twelve-week programme for victims and survivors of domestic abuse) to Ella whom they noted "regarded herself as a fighter", who may not accept offers of help and support. The police officers also

recorded that Ella would benefit from psychological therapies including counselling for sexual abuse and rape and from substance dependency services. The police officers noted that Ella might drink alcohol before being assessed by the Community Mental Health Team (CMHT) or her GP.

- 14.56 Whilst in hospital, Ella underwent substance detoxification and was medically fit for discharge on 5th June 2017. SaTH notified West Mercia Police that Ella had regained mental capacity and did not have Korsakoff's dementia or an enduring or treatable mental health condition. An MDT (Multi-Disciplinary Team) discharge meeting highlighted that Ella had been found temporary housing in bed and breakfast accommodation in another part of Shropshire. However, without support from a GP and a Care Act 2014 Needs Assessment, Ella would "likely fall straight back into the relationship and behaviours that placed her in hospital initially".
- 14.57 The Safeguarding Team at SaTH requested that the Integrated Care System (ICS) ensure that Ella's discharge plan included support from the CMHT and a GP referral and contact with the Shropshire Recovery Team (which provides support and advice to adults and young people who face challenges with drugs and alcohol). There was a concern that Ella was a repeat victim of domestic abuse, in which alcohol abuse was both a response to and a cause of abuse. It is not clear if the impact of Sean's alcohol use was also considered. The Risk Management Plan (RMP) for Ella was updated, and police officers would continue to monitor Sean and Ella's relationship. No action was taken in relation to the initial report of domestic abuse and the rape investigation was closed. However, from the records provided by ASC it appears no care and support needs assessment was made.
- 14.58 Ella was referred back to the MARAC on 7th June 2017. It is not clear why Ella was referred back, but it was possibly due to Ella's rape allegation(s). The MARAC decided that Ella was to be referred to Women's Aid and ASC was to notify Ella of this.
- 14.59 On 13th June 2017 Ella was discharged from SaTH into Accommodation 5 a shared accommodation placement in the county. It appears, however, that Ella spent most of her time at Sean's new accommodation at Accommodation 4, and on 26th June 2017 funding was withdrawn.
- 14.60 The safeguarding enquiry that was opened about Ella on 20th March 2017 was closed (date not specified by ASC, but likely to be in June 2017) as it was considered that the risks to Ella were reduced after Ella was admitted to SaTH and discharged to a placement.
- 14.61 In the evening of 24th June 2017, a local resident telephoned West Mercia Police since they could hear a woman screaming for help. Police officers located Ella, who appeared upset but would not engage with the police or disclose any offences. A male, thought to be Sean, was seen to be walking away from Ella. He was followed by police, but they stopped when they were unable to gain access to a block of flats that the male had entered. It appears that there was no subsequent confirmation that the male was Sean.

- 14.62 On 25th June 2017, police officers were called to reports of a woman shouting from within Accommodation 4 and established that Ella and Sean had argued over watching a television programme. Both were intoxicated. A DASH risk assessment was partially completed with Ella, who was assessed as at medium risk. Ella and Sean would not consent to a referral to domestic abuse services, but Ella agreed to leave the house to diffuse the situation. A referral was made to the First Point of Contact Team because Ella was open to adult safeguarding. The Domestic Abuse Unit was to monitor any further incidents between Ella and Sean.
- 14.63 On 18th July 2017 police officers attended Accommodation 4 as Ella had not been seen at Accommodation 5 for some time. Police officers found Ella there and noted that she was in good spirits, sober and able to hold a conversation. By this time the funding for Ella's accommodation had ended since she had moved in with Sean on a full-time basis.
- 14.64 On 23rd July 2017 a neighbour contacted West Mercia Police to report an argument at Accommodation 4. The police were unable to attend at that time but conducted a safe and well visit the following day. All was calm and Ella and Sean were referred to People2People, the ASC "front door".
- 14.65 On 27th July 2017 a local charity shop telephoned West Mercia Police reporting that two people, who were identified as Ella and Sean by police officers, were sitting outside the shop drinking alcohol and abusing passersby. Ella and Sean were escorted back to Accommodation 4.
- 14.66 In the early hours of 6th August 2017 Ella contacted West Mercia Police for help during a dispute with Sean over watching a film, which she later asked the police to ignore. Despite this, police officers tried but could not gain access to the block of flats in which Ella and Sean lived. After unsuccessful attempts, police officers contacted Ella by telephone later that day. Ella did not report any offences. The incident was referred to the Police Harm Assessment Unit (HAU) and was heard at a multi-agency Domestic Abuse Triage Meeting on 8th August 2017. The decision made during the meeting was that a referral would be submitted to the Community Mental Health Team, and this was completed on 9th August 2017. MPFT has stated that there is no record that a referral was received from West Mercia Police. A risk assessment identified a medium risk (it is not clear what the risk was and to whom), but no DASH was completed.
- 14.67 In the early hours of 9th August 2017, Ella telephoned for West Mercia Police attendance and explained that she and Sean had argued since he was stressed after being served a prohibition notice for his house. Ella and Sean agreed to sleep in separate rooms. Based on officers' knowledge a DASH assessment was completed and rated as medium risk. A HAU referral was submitted, and a Domestic Abuse Triage meeting was held on 9th August 2017. Ella and Sean were referred to People2People.

- 14.68 In the evening of 15th August 2017 police officers attended Accommodation 4 on three occasions following a report by a neighbour that a woman was screaming for someone to get off her and to stop dragging her. The neighbour informed the police that earlier in the day Ella had refused to let Sean into the flat and suggested the screaming may be related to this. When police officers attended Ella was heavily intoxicated, but quiet and said that Sean was asleep outside in his car.
- 14.69 In the evening of 16th August 2017, the neighbour notified West Mercia Police that it sounded like Ella and Sean were “battering” each other and “screaming their heads off”. The neighbour raised the concern that it always went quiet whenever the police arrived and there was often screaming from Ella when she was on her own. Police attended to find Ella alone and intoxicated. Ella was arrested for being drunk and disorderly and taken into police custody. Ella was seen by a health care worker who recorded that Ella had anxiety, depression, ADHD, borderline personality disorder, alcohol dependency and alcohol induced seizures. The custody Sergeant conducted a risk assessment and asked Ella if she wished to be contacted by an Independent Alcohol/Drug referral scheme worker. Ella requested alcohol support, and she was advised to also contact her GP. Ella was released from custody with no further action taken. It is not known if Ella engaged with support for alcohol use.
- 14.70 On 22nd August 2017 a neighbour notified West Mercia Police that an argument between Ella and Sean had escalated, and a fire alarm had been set off. The neighbour reported that arguing could be heard most nights, screaming was usually Ella only, but on this night, they could hear both Ella and Sean. When the police arrived neither Ella nor Sean wished to make a complaint against each other.
- 14.71 In the early hours of 10th September 2017, West Mercia Police attended following reports by a neighbour of a disturbance at Ella and Sean’s flat. Both were asleep and intoxicated but neither disclosed an offence against the other. Sean said he had had a long day at work and had been making telephone calls. Police officers left Ella and Sean to go back to sleep. They spoke with the neighbour who confirmed they had only heard a man’s voice.
- 14.72 In the evening of 16th September 2017, police officers attended following a report from a neighbour that a woman could be heard screaming from within the flat at Accommodation 4. Ella and Sean were found extremely intoxicated and quiet. Ella said that she had been shouting at Sean in a disagreement over “football”. Police Officers advised Ella and Sean to keep the noise down and they agreed to stay in different rooms but not to complete a DASH risk assessment. Police officers, however, assessed as medium risk. A domestic abuse triage meeting was held, and the case was referred to ASC, however, ASC has no record of receiving this referral.
- 14.73 On 20th September 2017 the police and ASC made a joint visit to Ella and Sean. Both were sober and Sean confirmed he had sold his property (Accommodation 2). Ella disclosed that not all their arguments were due to alcohol consumption and explained that she had suffered from depression from the age of 17 years old and at

times wanted to be left alone. Sean did not understand this, which resulted in arguments.

- 14.74 On 30th October 2017 Housing sent Sean a final warning letter about anti-social behaviour.
- 14.75 On 21st December 2017, West Mercia Police closed the RMP which had been opened on 1st December 2016 on the basis that the risk of harm had reduced. There had been fewer police callouts to Ella and Sean's home, neither of them had disclosed any incidents or offences and Ella and Sean did not want to engage with services. West Mercia Police noted Ella's refusal of assistance, lifestyle choice, freewill and choice to consume alcohol despite its effect on her health.
- 14.76 On 23rd December 2017 the police received a call from a third-party reporting screaming and shouting from Ella and Sean's address. When police officers attended Ella and Sean confirmed that they had had an argument over Ella wanting to go to sleep. Sean was removed from the property and placed in the care of his sister. A referral was made to the HAU. A DASH was not completed since Ella and Sean were too intoxicated.
- 14.77 On 26th December 2017 Ella attended the Emergency Department at SaTH with a minor head injury and alcohol withdrawal. Ella was admitted to hospital and treated for hypokalaemia secondary to vomiting. A CT head scan showed no intracranial haemorrhage. SaTH did not identify any safeguarding concerns and noted the head injury was due to a fall while intoxicated. Ella was discharged on 28th December 2017.
- 14.78 **Year 2018**
- 14.79 From 2018 and up to 2023 there was limited contact between the police and Sean and Ella.
- 14.80 On 18th January 2018 Ella made an emergency call after attempting to self-detoxify. An ambulance crew attended and advised Ella to go to the Emergency Department for further management of her detoxification, but Ella declined. The crew informed Ella's GP, administered an anti-sickness drug and arranged for a further prescription to be collected by Sean.
- 14.81 On 30th January 2018 a call was taken by the police reporting shouting and swearing at Ella and Sean's address. On arrival, Sean and Ella told officers that they had got engaged to be married. Officers reported that all was in order and no further action was taken.
- 14.82 On 3rd February 2018, Sean called for an ambulance as Ella had experienced a seizure and had spent the day in bed. Ella was admitted to SaTH. A CT scan indicated that Ella had suffered a subdural haematoma (a blood clot that forms between the brain and the skull after a head injury). Ella was transferred on 5th February 2018 to Royal Stoke

University Hospital (RSUH) part of the University of North Midlands NHS Trust for treatment. During surgery Ella was found to have an infection which had caused a subdural empyema (pus from an infection). This was treated. On 16th February 2018 a further CT scan found empyema still present and, consequently, further surgery was undertaken. Throughout her stay at RSUH Ella was confused and at times agitated and belligerent towards staff. The mental health team based at RSUH reviewed Ella and concluded that this was due to delirium caused by the brain surgery. A “therapies” review completed on 27th February suggested that Ella would benefit from a social review and a functional assessment. It appears that Ella’s condition had caused a stroke, which in turn had caused weakness in the left side of her body. There is, however, no record of a functional or care and support needs assessment. Ella was assessed as requiring rehabilitation and was discharged back to SaTH on 28th February 2018. According to the discharge letter provided by SaTH to Ella’s GP, the infection in Ella’s brain was identified as E. coli.

- 14.83 GP Surgery A, Ella’s current GP was notified of Ella’s admission to hospital by SaTH.
- 14.84 On 4th February 2018 ASC closed a Section 42 Care Act 2014 safeguarding enquiry. There are no longer records of this, but it appears that due consideration was given to this case by a team manager.
- 14.85 On 8th February 2018, a neighbour called West Mercia Police to report that males and females could be heard arguing at a party in Ella and Sean’s flat at Accommodation 4. Officers attended and ended the party. Ella was not there as she was in hospital.
- 14.86 On 7th March 2018, the RAID team concluded that Ella lacked the mental capacity to refuse post-surgery treatment with antibiotics.
- 14.87 On 23rd March 2018 Ella was transferred to a rehabilitation ward of Princess Royal Hospital.
- 14.88 On 5th April 2018 Ella and Sean were offered temporary accommodation at the Accommodation 6. Sean was being evicted from Accommodation 6 for anti-social behaviour. Ella was being discharged from hospital and wanted to be housed with Sean.
- 14.89 However, on 12th April 2018 Accommodation 6 asked Ella and Sean to leave because they had made their room messy and unhygienic and notified Housing of this. In turn, Housing contacted the safeguarding team and were advised that since Ella and Sean did not have care and support needs, they would not be classed as vulnerable. Housing believed that its duty to provide emergency accommodation was discharged.
- 14.90 From 13th April 2018 Ella and Sean were of no fixed abode.
- 14.91 On 22nd April 2018 Ella and Sean moved to Accommodation 8 but on 29th April 2018, West Mercia Police were advised that Ella and Sean had been asked to leave due to causing disturbances. Ella and Sean said they were going to check into a Holiday Inn.

- 14.92 On 20th June 2018 Ella did not attend a neurology outpatient's appointment following her admission to hospital in February 2018. Ella remained, at this stage, of no fixed abode.
- 14.93 On 5th July 2018, Ella was brought to the Emergency Department of SaTH by WMAS with a fractured humerus (upper arm) "secondary to alcohol". Ella had been found on the ground outside a pub, where it appears Ella and Sean had been staying. Ella had told Sean that she had fallen in the pub garden, but she told the ambulance crew that she had fallen downstairs. SaTH noted Ella's history of domestic abuse and explored the reasons for her injury. On 15th August 2018 Ella's GP received notification of Ella's Emergency Department attendance.
- 14.94 On 18th July 2018 Ella did not attend a neurology outpatient's appointment, and she was therefore discharged. The neurology department wrote to Ella's GP accordingly, asked for an update on Ella's progress and suggested that the GP could re-refer Ella to the department if necessary.
- 14.95 On 8th August 2018 Ella did not attend a nerve injury clinic appointment and was discharged. Her GP was notified.
- 14.96 On 18th September 2018 Ella was admitted to SaTH with a fractured scaphoid (break to bone in the wrist) and with right parietal circulation stroke (partial seizures). SaTH considered it likely that Ella had suffered a stroke two weeks prior to her admission. Ella referred to a recent fall downstairs and that she used alcohol as pain relief. It is not clear whether this related to the fall she had on 5th July 2018. Ella's previous history of domestic abuse was explored but she made no disclosures. Ella told the hospital she had been living in a tent on her own since being made homeless in March 2018 and that Sean brought her food and alcohol.
- 14.97 On 16th October 2018 Ella's GP reviewed concerns about Ella's missed neurological appointments and decided no action was required.
- 14.98 SaTH made referrals to ASC as Ella was homeless and arranged for physiotherapy, occupational therapy, dieticians, speech and language therapy and stroke rehabilitation. It was noted that Ella had difficulties mobilising since her fall downstairs. Ella required the assistance of a quad stick for washing and dressing and for transferring. During her stay in hospital Ella received alcohol detoxification treatment.
- 14.99 On 19th October 2018 Housing visited Ella in SaTH and supported her to make a homelessness application.
- 14.100 On 6th November 2018 a social work assistant visited Ella in SaTH Ella told the social work assistant that she wished to be with her partner and her cats, but that Accommodation 5 could not accommodate this.

- 14.101 On 9th November 2018 the social work assistant returned and advised that Ella that Accommodation 10 could accept her. Ella agreed to be discharged from SaTH to Accommodation 10.
- 14.102 On 12th November 2018 Ella was discharged to Accommodation 10. From 15th November 2018 Ella was registered with GP Surgery B.
- 14.103 On 23rd November 2018 Ella's GP discussed making a referral to an epilepsy specialist with someone (possibly Ella's carer, according to the note), but as Ella was to be moving again, it was decided to wait until the new location was known.
- 14.104 On 26th November 2018 Ella was offered an adapted bungalow (Accommodation 11) to enable the delivery of her care and support needs. Ella moved in on 3rd December 2018, and Sean agreed to take Ella there and to help with shopping.
- 14.105 On 13th December 2018 Ella registered with GP Surgery C. Ella completed an alcohol questionnaire as part of the registration process and a "brief" intervention followed, but it is not noted what this was. On 14th December 2018 her new GP visited Ella at home.
- 14.106 **Year 2019**
- 14.107 On 2nd January 2019 Ella was referred to neurology for an epilepsy follow up.
- 14.108 On 4th January 2019 WMAS took Ella to a local Minor Injuries Unit, following a fall at home. Ella's GP was notified that Ella had fractured her wrist.
- 14.109 On 7th January 2019 two social care practitioners visited Ella and noted Ella's fractured wrist, that Ella had cancelled her carers as Sean was off sick from work and that he would support her, and that there were a lot of empty bottles and cans of alcohol in the bedroom.
- 14.110 On 25th January 2019, Ella's care and support package was ended because she did not engage with the support provided. Consequently, Housing offered Ella and Sean new interim accommodation, as the adapted bungalow was no longer required. According to ASC, Housing notified ASC that Ella and Sean had been given notice to leave Accommodation 11 due to "neglect and disregard of the bungalow".
- 14.111 On 4th February 2019 Ella and Sean moved into new interim accommodation at Accommodation 3. The hotel was also referred to as a hostel.
- 14.112 On 26th February 2019 the neurology service notified Ella's GP that it had had no contact from Ella.
- 14.113 On 11th March 2019 Ella's GP received a letter from the fracture clinic to advise that Ella had not attended/ she had not been brought to her appointment and therefore had been discharged.

- 14.114 On 27th March 2019 Housing referred Ella to ASC for a care needs assessment, noting Ella's mobility difficulties and need for help with medication administration. There was no consent from Ella for the referral. ASC discussed the referral with Housing but had no record of any direct contact with Ella about her needs at this time, or of a care and support needs assessment having been made. However, Sean was added onto ASC's database as Ella's carer on 27th March 2019.
- 14.115 On 3rd April 2019 Housing Support (who, at the time, were contracted by Shropshire Council to provide support to people in temporary accommodation) contacted ASC as Ella's bank account had been emptied. Ella said she had not given permission for anyone to access her account, but Sean had the PIN number and therefore her bank would not cover the loss. On 10th April Housing Support contacted ASC again about the theft of money and a concern that Ella had not registered with a GP.
- 14.116 On 15th April 2019 Ella attended the Emergency Department with a shoulder injury. Ella did not attend/ was not brought to a follow up appointment. At this time Ella was noted to be of no fixed abode.
- 14.117 On 24th April 2019 Accommodation 3, who was concerned about the presentation of both Ella and Sean, advised ASC that Ella was not eating properly and that she only seemed to use the accommodation on a Wednesday.
- 14.118 On 24th April 2019 ASC and Housing arranged a joint visit to Ella for 3rd May 2019. However, there is no note in ASC and Housing's records that this visit took place.
- 14.119 On 20th May 2019 Accommodation 3 advised ASC that Ella's home environment was getting worse due to the smell of alcohol and general neglect due to Ella's decreased mobility.
- 14.120 On 24th May 2019, following discussion between ASC and a district nurse, Ella was brought by WMAS and was admitted to SaTH due to decreased mobility and an increased number of seizures. WMAS raised a safeguarding concern with ASC (received on 28th May 2019), noting that Ella was self-neglecting, was unable to self-care, Accommodation 3 was not staffed full time and that residents at the hotel were entering Ella's room and taking her money and belongings.
- 14.121 The safeguarding concern from WMAS also noted that Sean was staying in Ella's room overnight and was out during the day. The hotel manager said that Sean was locking the door to the "flat" on a regular basis, leaving Ella without food. The manager often had to unlock the door for Ella as she was screaming. Other residents would go into Ella's room and wash her and take large amounts of money from her for helping her. Housing also alerted ASC to concerns that a MAPPA 1 schedule offender (sex offender) was staying at the same hotel as Ella and had been seen twice in Ella's room. Ella was very vulnerable and unable to defend herself. It was thought that the MAPPA 1 offender had been paid by Sean to do some cleaning. It is not clear if the cleaning was done in Ella's room.

- 14.122 These concerns were followed up by SaTH as Ella was in hospital. SaTH informed ASC that it did not think there were any safeguarding concerns, but that ASC needed to be involved. Ella told SaTH that Sean was good to her and that the person who washed her was the hotel manager's girlfriend. Ella denied that she knew anything about her money being taken.
- 14.123 Ella was discharged from SaTH to a bed at a Community Hospital for further rehabilitation and on 31st May 2019 SaTH notified Ella's GP that Ella had completed an alcohol detoxification but had poor mobility and frequent seizures.
- 14.124 On 15th June 2019 Ella was discharged from the Community Hospital to Accommodation 12.
- 14.125 On 26th June 2019 a new social worker visited Ella at Accommodation 12. Ella was able to mobilise with a stick. Ella agreed to have the need for sheltered accommodation removed from her housing application as this would enhance her chances of securing a property and consented to the social worker making bids for housing on her behalf.
- 14.126 In July 2019 Ella's GP surgery changed to GP Surgery D.
- 14.127 On 10th July 2019 the Deputy Manager of Accommodation 12 reported to ASC that Ella had no money in her account.
- 14.128 On 12th July 2019 the new social worker visited Ella at Accommodation 12 following concerns raised by the care home staff and an Independent Living Worker (ILW) regarding Ella's finances and lack of money in her account. Care home staff thought that someone other than Ella was taking money from her account. Ella was unable to tell the social worker where the money had gone. Ella had been receiving state benefits direct into her account. The social worker contacted the Department for Work and Pensions who advised that the benefits had stopped being paid into Ella's account in December 2018 as she had not attended a medical review. Subsequently the matter was resolved, and Ella's benefits were reinstated.
- 14.129 On 9th August 2019 Housing accepted full housing duty to both applicants (Ella and Sean) who had made a joint application for homelessness.
- 14.130 On 4th September 2019 the ILW told the social worker that she was concerned that when Ella was offered accommodation, she would not receive any assistance because Sean had money in his bank from the sale of his property. The ILW was also concerned that Sean was not making any effort to visit Ella and that he had spent a week away in another part of the UK without her knowledge. The ILW and social worker remained concerned about the possible influence Sean had on Ella and his effect on Ella's alcohol intake. They were to arrange a meeting with Ella, but it is not clear whether the meeting took place. ASC has no record of contact with Ella from this time until 9th October 2019.

- 14.131 On 12th September 2019 Ella referred herself to With You (Drug and alcohol support). Ella told With You that she had stopped drinking alcohol due to living in a “hospice” where such substances were not allowed. Ella told the service that she used to drink through boredom. She also said that Sean drank excessively and that they hoped to move into Ella’s new accommodation when Ella was discharged from Accommodation 12.
- 14.132 On 16th September 2019 Ella attended the fracture clinic as she had gone out with Sean and fallen out of Sean’s car landing on her left wrist two days previously. This was a second injury to her hemiplegic arm. Shropshire Community Health NHS Trust reflected that there was a lack of professional curiosity from its practitioners around how Ella had fallen out of the car. Ella received help from a physiotherapist.
- 14.133 On 9th October 2019 Ella told the social worker about the fracture of her left wrist. The social worker commented to Ella that she tended to sustain injuries when she was with Sean. Ella denied this was case.
- 14.134 On 17th October 2019 the physiotherapist made a referral to an outpatient neuro physiotherapist for an opinion on management of increased tone and contracture in Ella’s left arm. Hypertonia is a condition where there is too much muscle tone so that it is difficult for arms or legs to relax. Contracture is a permanent or temporary tightening of muscles, tendons, skin and nearby tissue which limits joint movement.
- 14.135 On 22nd October 2019 Ella attended her first appointment with a key worker from With You.
- 14.136 On 25th October 2019 and 4th December 2019 Sean attended his current GP surgery, about shoulder pain. Sean told his GP that his girlfriend had had a stroke, and he had had to “pull her up”. Sean continued to have sick notes from the Practice for his shoulder until the end of March 2020.
- 14.137 On 31st October 2019 Ella was discharged from the physiotherapist as Ella was now being seen by the neuro physiotherapist.
- 14.138 On 12th November 2019 Ella attended a second appointment with a keyworker from With You and Ella talked about a new future with her partner. Ella presented well and stated that she was feeling better for not drinking. They had a discussion about the benefits of not drinking, including emotional and physical health. The meeting focussed on her strengths, on what she could do, rather than what she could not do. Ella said she was waiting for her own property once she had been discharged from Accommodation 12. Following this meeting Ella did not attend again. With You made four attempts to re-engage Ella, by phone and letter, without success.
- 14.139 In December 2019 Sean was removed from Ella’s application for homelessness. On 13th December 2019 Housing noted that Sean was to be considered for a property in another part of Shropshire. However, Sean did not attend a meeting arranged to

discuss and view the property with the social landlord. A second meeting was offered but Sean arrived with “two undesirables known to safeguarding” and consequently no offer was made.

14.140 Sean did not respond to calls from social landlords and from Housing, resulting in Housing losing contact with him.

14.141 Year 2020

14.142 On 14th January 2020 an urgent referral to neurology was sent by Ella’s GP. This was due to Ella’s increased frequency of seizures.

14.143 On 24th January 2020 the social worker took Ella to see a property she had been offered. On 27th January 2020 Ella signed the paperwork for the property. She was taken to the meeting by Sean. The social worker had explained to Ella and Sean that the tenancy was Ella’s alone and that property was still being sought for Sean in his own right.

14.144 On 31st January 2020 the neurology referral was “re-processed” at the request of the Referral Assessment Service as Ella’s new GP requested that Botox injections be considered for Ella’s contractures in her left arm. An appointment was arranged for June 2020. At the time referral information stated that Ella was residing at Accommodation 12.

14.145 On 7th March 2020 Ella moved into her new accommodation, a tenancy at Accommodation 13. Ella was supported by a Care Agency B worker, the ILW and received four care calls a day from Care Agency C supporting Ella with personal care, medication, meals and drinks. Ella was reportedly sober since June 2019.

14.146 On 11th and 12th March 2020 a social care practitioner visited Ella who was happy settling into her new accommodation. Sean was present throughout the review.

14.147 On 12th March 2020 Ella registered with GP Surgery D.

14.148 In March 2020 Sean returned to work.

14.149 On 7th May 2020 it was reported to Housing that Sean had moved in with Ella.

14.150 On both 18th June and 15th July 2020 staff at the neurology department were unable to contact Ella for a telephone consultation using the contact details which had been provided by Ella’s GP. The neurology department wrote to Ella’s new address as well as asking Ella’s GP for updated contact details for Ella.

14.151 Year 2021

14.152 On 11th February 2021 a social worker told Ella’s GP practice that Ella had been receiving four care calls a day, but this arrangement was being stopped because Ella kept cancelling calls. The social worker also commented on the state of Ella’s

accommodation (rodent droppings and piles of rubbish), about concerns that Ella had started drinking again and that Ella may not be able to administer her own medication when care calls stop because she could not use her left hand to open pill pouches. The GP planned to review Ella's alcohol use. Patient records show that blister packs were used for medication, but it is not clear when this started.

14.153 On 29th July 2021 a social care practitioner completed a reassessment of Ella. Ella told the practitioner she was accepting of four care calls per day and that she cancels calls when Sean is at home with her, which is usually a Sunday. The social care practitioner noted that Ella's home was "unkempt".

14.154 On 4th December 2021 a 999 call was made (it is not noted by whom) and, subsequently, on the morning of 5th December, Ella was taken to SaTH by ambulance because Ella had sustained a soft tissue injury to her left wrist following a fall on 3rd December. The hospital completed a safeguarding screening tool and Ella told the hospital that she fell while intoxicated. Ella was discharged from the emergency department on 5th December.

14.155 Year 2022

14.156 On 7th January 2022 Care Agency C notified ASC that Sean was at Ella's address more often and that the home environment was deteriorating further.

14.157 On 1st February 2022 the social care practitioner and a representative from Care Agency C sought to visit Ella. There was no key in the key safe. They called Ella on her telephone, but she did not answer. They knocked on doors and windows, and Sean answered and asked them to go away. ASC gave the care agency two weeks' notice for its services to Ella to come to an end.

14.158 On 4th February 2022 the social care practitioner visited Ella and told her that the support from the current care provider was going to end. She explained that support would be rearranged, but because of the Covid-19 pandemic's impact on services it was difficult to find support at this time. Sean would need to do the shopping for Ella, for the time being.

14.159 On 15th February 2022, during a telephone conversation, the social care practitioner offered Ella the opportunity to be referred to a service for shopping. Ella replied that Sean was thinking of being her carer, as he was at her address more permanently and they both (Ella and Sean) wanted Sean to live there full time.

14.160 Further visits by the social care practitioner on 1st and 25th March 2022 showed that the state of the property was continuing to get worse. Ella was offered a care provider, but she declined saying that Sean was supporting her now.

14.161 On 21st April 2022 Ella had a fall. On 24th April Ella called for an ambulance as she had suffered pain in her left shin ever since the fall. The ambulance report stated Ella had fallen and hurt her leg when transferring from her commode to her bed and that care

visits had been discontinued in February 2022. The ambulance crew assessed that Ella did not need to be transported to hospital, but Ella insisted that she be taken. Ella was subsequently admitted to SaTH.

- 14.162 WMAS made a safeguarding referral to ASC for self-neglect including Ella's unkempt home environment and a lack of care she was receiving. ASC did not progress the referral to a Section 42 enquiry as there did not appear to be any allegation of risk of on-going abuse by a third party.
- 14.163 On 6th May 2022 Ella was transferred from SaTH to a Community Hospital. The discharge report from SaTH noted that Ella had fallen on her left side, had struggled to mobilise, limited by pain caused by the soft tissue injury, and had not recovered her baseline mobility of walking with a stick. The hospital report also noted that Ella had 1 to 8 seizures a day and had been reviewed by the neurology team who suggested these seizures were likely due to alcohol withdrawal and non-compliance with medication. Ella was advised to continue with Lamotrigine medication. It was also noted that Ella had functional urinary incontinence, due to limited mobility with left hemiparesis and fear of falling. The SaTH safeguarding team requested a care and support needs assessment for Ella and discharge planning prior to sending Ella home. There is no care and support needs assessment noted as having been carried out at this time.
- 14.164 On 25th May 2022 a Memory and Wellbeing Practitioner met with Ella in the Community Hospital. Ella expressed frustration at her limited mobility and told the practitioner that she felt like a burden to her fiancée of three years, "before they were even married". The practitioner discussed discharge options with Ella. Ella was clear that she wished to be discharged with a care package but appeared reluctant to engage with therapy assessments to aid her discharge planning. A referral was made to the hospital discharge service as Ella was not making her own decisions regarding discharge planning. However, there was no concern about her mental capacity. No mental capacity assessment was made, but an assessment determined that Ella did not have signs of dementia. Ella was to be seen by an occupational therapist who would assess her for assistive devices and observe Ella's short distance walking with a quad stick.
- 14.165 On 9th June 2022 Ella was discharged from the Community Hospital to Accommodation 14 for (step down) residential care. Ella was to be supported in the community by the ICS (Integrated Community Support) team for mobility and equipment provision. During her stay in residential care, carers struggled to engage Ella with the care they were contracted to provide.
- 14.166 On 21st June 2022 Ella was discharged from the ICS team as she was deemed to be independently mobile.
- 14.167 On 6th July 2022 there is a note in the electronic patient records that a referral to the memory clinic had been suggested for Ella. The memory clinic, however, would not

see patients who drank above the national recommended limits for alcohol. It appears, therefore, that Ella was not seen by the memory clinic.

- 14.168 On 22nd August 2022 Ella was discharged from Accommodation 14 and carers from Care Agency D (which also ran Accommodation 14) started to make two care calls a day to Ella at home (Accommodation 13).
- 14.169 Care Agency D carers were “appalled” by the conditions Ella was living in. Ella and Sean often turned carers away. Ella told Care Agency D that she did not want care anymore as Sean was going to provide it.
- 14.170 On 8th October 2022 Sean’s manager called the police reporting his concern that Sean had not attended work that day, and that Sean was alcohol dependent. Police officers were dispatched to Accommodation 13. Ella answered the door and told officers Sean was not there.
- 14.171 On 12th October 2022 Sean’s manager called the police again. He was growing increasingly concerned for Sean. He explained to the police that Sean had previously gone missing in 2019 when there had been an alcohol related incident where he had left home and become homeless for a time. There was concern on this occasion that there was a domestic element to Sean’s disappearance as there had been rumours in the workplace that Sean was a victim of domestic abuse perpetrated by Ella. There was mention amongst colleagues of a video of Sean being assaulted by Ella. Sean’s manager had contacted Ella to ask her if she had seen Sean, however Ella was evasive. The police attended Ella and Sean’s address, where Sean told police that he needed to get away for a few days as the hours of work were too much for him. Sean agreed to speak to his manager.

14.172 **Year 2023**

- 14.173 On the evening of 12th May 2023 Ella had a fall, was unable to get up, and telephoned 999. The West Mercia Police received a telephone call from a landline number associated with Ella and Sean’s address. The call taker told the police that a television could be heard in the background and a female possibly saying, “help me”. The call taker asked what was wrong and heard someone say, “I don’t know”. The call taker recorded that they did not know if the voice was from the television which was very loud or was a person at the address. It appears that no police officers were dispatched to attend the address. There was nothing recorded on the police log for this incident to link the address to Ella and Sean. If this had been checked and updated the domestic history between them would have prompted officers to be dispatched.
- 14.174 At approximately 22:30 hours the same evening, WMAS attended Ella, helped her up and put her back to bed. Ella appeared unhurt but declined all advice from the crew, including a safeguarding referral. The crew assessed she had the capacity to make this decision. Ella said that Sean was her carer and she did not need any help. Ella told the crew that she had had a drink that evening, and alcohol was a risk, but she was

not intoxicated. The crew described the property as very untidy with many beer cans in the bedroom.

- 14.175 In its report of this attendance to Ella's GP, WMAS stated that, "a referral has been made via EOC/ Crew/ Patient to contact patient's GP". WMAS meant by this that Ella's GP should visit Ella. However, the administrative staff at the GP practice interpreted this report as meaning that Ella would contact the practice for review. Consequently, the document was filed rather than being forwarded to a GP for review.
- 14.176 Police Officers attended Sean and Ella's address at 10:00 one morning (date not specified by West Mercia Police, but likely to have been in July 2023) regarding a matter concerning Sean's car. During their visit the police noted that Ella asked Sean for alcohol and that their home was littered with empty alcohol bottles and cans.
- 14.177 On 2nd August 2023 WMAS was called out to Ella (it is not noted by whom). Ella had had a fall while moving from her bed to her commode. She reported no injury but just wanted to be assisted to her feet. The crew made a safeguarding referral to ASC regarding self-neglect. The crew made the referral in Ella's best interests because although she was deemed to have capacity, Ella was intoxicated and the crew felt it was not safe to walk away without raising concerns about this case. WMAS noted in the referral that the house was in poor condition with rotten food presenting a serious health and safety hazard, and there were bags of empty alcohol bottles. Ella was lying on a broken bed with a heavily stained duvet cover. Ella was potentially taking out of date medication, and she refused all medical assistance and hospital attendance. Sean was reported as her carer but he was out. WMAS sent a full report to Ella's GP. WMAS has commented, on reflection, that the level of documentation was excellent and painted a clear picture of the conditions Ella was living in and the significant decline in the state of the property. However, the note on the patient's record was again misinterpreted by administrative staff at the GP practice who understood that Ella was to contact the GP practice rather than the other way around. Consequently, the note was not passed to a clinician for action.
- 14.178 On 18th December 2023 Sean called for an ambulance to their home as Ella was lying on the floor. Sean reported that Ella had fallen out of bed two days earlier and that he had left her there. The ambulance crew found Ella living in squalid conditions and described Ella as being very poorly, barely conscious, and with what appeared to be wound marks on the back of her knees and her buttocks. Ella was wearing a top and one hospital sock but nothing else. The crew took Ella to SaTH as an emergency because they believed her condition to be critical. The ambulance crew then contacted West Mercia Police to report its concerns about Ella. The police telephoned and later visited SaTH to understand more about Ella's condition. Ella was hypothermic with a temperature of 26 degrees centigrade and low blood pressure. Ella was unable to communicate, and the hospital was unable to confirm what had caused Ella to be in the condition she was.
- 14.179 The police attended Ella and Sean's home. Given the condition of the property and the apparent neglect of Ella and her needs the police arrested Sean on suspicion of ill

treatment and neglect of Ella. Sean was released on police bail following a discussion regarding his living conditions, own self-care and that he may be an adult with care and support needs. Subsequently a criminal investigation concluded with no further action.

15. Overview of Ella's and Sean's contact with services

- 15.1 It would appear clear that Ella was being domestically abused by Sean. In December 2016, following a MARAC referral when Ella had disclosed that she had been emotionally abused by Sean, a Domestic Abuse Risk Management Plan (RMP) was created for Ella and Sean. The purpose of this plan was to monitor their relationship, check on their welfare and offer support to them both. The plan was in place until December 2017 and during this time West Mercia Police visited Ella and Sean sometimes with support from ASC. During 2017 domestic abuse incidents and "emotional domestic incidents" were reported to and responded to individually by West Mercia Police. Often police officers were unable to distinguish between the perpetrator and the victim and usually both Ella and Sean were under the influence of alcohol. Both Sean and Ella engaged with housing services to find accommodation for them.
- 15.2 Ella was seen by WMAS and attended the Emergency Department of SaTH several times during the review period. Ella had five stays in hospital, each for a period of one or more months, including some transfers between hospitals. Ella had support from Shropshire Community Health NHS Trust (SCHT) for mobility, continence and equipment provision. Ella had limited contact with mental health services and, generally, the contact she did have was during stays in hospital. Ella engaged well with the alcohol support service, "With You", for three months in 2019, but had no contact otherwise, despite attempts by With You to reengage with her. There is no recorded contact with domestic abuse services. There were two periods of time when Ella was supported at home with daily care visits. These stopped in November 2022 as Sean was to be Ella's full time sole carer. Consequently, at the time of her death on 18th December 2023, there had been 13 months of no face-to-face contact by services except for two visits from WMAS and one from West Mercia Police.
- 15.3 Between 2017 and 2023 Ella had moved between five GP practices. During this time, Ella had a face-to-face consultation with a GP on five occasions and with an advanced nurse practitioner on one occasion. There were several occasions where a carer contacted Ella's GP on Ella's behalf. A GP from the last medical practice with which Ella was registered before she died, attempted to contact Ella several times by telephone and letter in 2022, without success. However, on 18th August 2022 a GP was able to visit Ella at Accommodation 14 residential home. This was the last time Ella had a consultation with a GP face to face.
- 15.4 None of the GP consultations appeared to include enquiry into whether Ella was experiencing abuse. A hospital discharge/transfer letter to Ella's GP on 28th February 2018 had mentioned domestic abuse, but there did not appear to be any follow-up from a GP once Ella was at home.

- 15.5 Sean had contact with the Environmental Health Department of Shropshire Council about his house which was uninhabitable, his GP(s), SCHAT for physiotherapy services after Sean had physically moved Ella, the police, ASC and housing.

16. Analysis

- 16.1 The actions and interactions of the agencies involved with Ella and Sean will be analysed using the Terms of Reference for this DHR.

- 16.2 **The extent to which domestic abuse, including coercion and control, was recognised and responded to, including:**

16.3 Recognition of domestic abuse and coercive control

- 16.4 Analysis of the chronology and the IMRs revealed the following ways in which Ella was potentially coerced, controlled, abused and neglected by Sean:

Ways in which Ella was potentially coerced, controlled and neglected by Sean. These are listed irrespective of whether agencies had recognised an action / inaction or event as potential abuse or neglect.
On 28 th November 2016, SaTH made a MARAC referral following a disclosure by Ella to hospital staff that Sean was emotionally abusing her. Ella said that she was scared of Sean when he lost his temper, that she felt isolated, and that Sean was controlling. This led to the creation of a Risk Management Plan for Ella and Sean which operated from 1st December 2016 until December 2017.
Sean may have neglected Ella by not supporting her with dressing, personal care and hygiene. (Housing IMR 14 th March 2017). Ella was in a state of undress and told Housing that Sean had taken her clothes.
It appears Sean tried to prevent agencies from seeing Ella, for example the ASC representative had to persuade Sean to allow her to see Ella on 28 th April 2017. On many occasions during 2022 Sean and Ella turned care workers away who were trying to provide care for Ella at home. It is not clear whether agencies considered the possibility that Sean wanted to avoid partner agencies and care providers seeing the state of neglect that Ella was living in.
A MARAC referral was made by SaTH on the basis of bruising seen on Ella once she had been admitted to SaTH on 28 th April 2017. According to West Mercia Police, officers with the assistance of nursing staff, checked bruising on Ella's skin on 30 th April 2017. There were bruises evident on her arms, but hospital staff explained that these were from them trying to take blood.
Ella alleged that Sean had raped her. She later withdrew the allegation (police IMR April/May 2017). This was the report of a crime and an example of the abuse that Ella experienced. Ella's withdrawal of the allegation may also have been due to fear of the consequences of making a complaint about Sean.
Ella said that she feared Sean, that he was controlling and alleged that he did not allow her to see her friend. Ella also said that he had previously hit her and had tried to sexually assault her (police IMR 30 th April 2017). Ella also said that Sean

was playing “mind games” with her and, due to her mental state at the time, she had believed him. No further details of the mind games were recorded, but this may have been an indication that Sean was “gaslighting” Ella, a familiar tactic in domestic abuse.
In May/June 2017 Ella told the assessing clinician in the RAID team that Sean kept her drunk to stop her leaving him and that Sean had touched her inappropriately. Ella told the police that she had attempted to leave Sean numerous times in 2017. (Police IMR). This was an example of the control that Sean exerted over Ella.
Neighbours reported frequent arguments between Ella and Sean to West Mercia Police (Police IMR from 24 th June to 23 rd December 2017). Whilst domestic arguments are not necessarily domestic abuse, in the context of the other concerns raised by and about Ella, they may have been an indicator of coercion or abuse.
In February 2018 it was originally thought that Ella had suffered a traumatic subdural haematoma caused by a head injury. Subsequently it was found that Ella had experienced a subdural empyema, which was highly unlikely to have been caused by a head injury. Ella had, however, suffered several physical injuries during the timeframe for this Review. It is unknown whether any were caused by Sean. For some, explanations were given that Ella had fallen (for example, SaTH IMR 26 th December 2017 and WMAS IMR 4 th January 2019).
West Mercia police noted that Ella’s condition in 2018 left Ella with significant physical health needs including restricted mobility, after which she was cared for by Sean. However, reports of domestic abuse to the police also reduced significantly. Ella’s reduced mobility and greater dependence on Sean may have reduced her opportunities to call for help, whilst increasing her vulnerability and reliance on him.
On 24 th May 2019 the hotel manager where Ella was staying said that Sean locked Ella in her room during the day without food. This was a further example that Ella was being controlled by Sean.
There were reports of bedding being soiled (Ella’s bed at home and at a hotel ASC IMR 24 th May 2019). This suggested that Ella’s personal care needs were neglected.
Other residents at the hotel where Ella was staying took Ella’s belongings. Some provided some form of care for Ella, for which they paid themselves from Ella’s money (May 2019). Sean knew Ella’s PIN number and money appeared to be missing from Ella’s bank account (Accommodation 12 IMR July 2019), which Sean did not help to resolve. These were examples of possible economic abuse, about which there were concerns at the time.
Sean and Ella refused to allow carers to visit Ella (February 2021 into 2022). This may have been an example of the control Sean exerted.
On 25 th May 2022 Ella told a memory and wellbeing practitioner that she was frustrated with her limited mobility and she felt like a burden to Sean. This may have been an example of Sean’s coercion of Ella, which made her blame herself.
In December 2023, Ella was left by Sean on the floor, partially unclothed and uncovered, when she had fallen out of bed. On 18 th December 2023, at least two days later, Sean called for an ambulance. This may have been an example of Sean’s control over Ella about when she would receive help.

- 16.5 Despite these possible indicators, there was variable recognition of domestic abuse in Ella's life. West Mercia Police was aware that Ella had experienced domestic abuse in previous relationships and also recognised the domestic abuse and coercive control of Ella by Sean. However, West Mercia Police was often unable to distinguish between the perpetrator and victim. The dynamics of abuse may have been obscured by a focus on mutual vulnerability, alcohol misuse and incident-based responses. The failure to identify who was causing harm reduced perpetrator accountability and may have resulted in interventions that did not fully reflect the nature, seriousness and cumulative impact of abuse. SaTH had also recognised the domestic abuse of Ella by Sean and had a raised MARAC referrals in 2016 and 2017 and also notified the RSUH of domestic abuse in 2018.
- 16.6 Housing was initially unaware of domestic abuse in Ella's life but became aware of the presence of control by Sean, when Ella said that Sean had taken her clothes from her. ASC also became aware that Ella may have been controlled by Sean when he was reluctant to allow them to see her.
- 16.7 Ella and Sean's use of alcohol may have presented a barrier to the recognition of domestic abuse. Many of the incidents reported to the police were late at night when both Ella and Sean were often under the influence of alcohol. Substance dependency can be a barrier to both disclosure and help seeking for both domestic abuse and also for substance dependency itself.
- 16.8 GP Surgery D had no knowledge that Ella was being domestically abused by Sean. There were a few references to a history of domestic abuse in the GP records, but these were not apparent unless the documents attached were opened, and it was not clear in the records who the perpetrator of abuse was. The practice stated that had the records been "coded" to show domestic abuse, this may have prompted GP practice staff to ask more about Ella's history and risks during consultations. The records also showed a history of childhood trauma, but again this had not been "coded", so was not seen by practice staff.
- 16.9 Apart from Ella's allegation of rape in 2017, MPFT was not aware of any other reports of domestic abuse that occurred during the scoping period. Neither was With You (Drug and Alcohol Support).
- 16.10 Care Agency D was also not aware of any domestic abuse of Ella by Sean. Ella had freely shared information about her life with the care workers from Care Agency D and for this reason Care Agency D was surprised to learn through this Review process that domestic abuse may have taken place. It is possible that no domestic abuse occurred at times when carers from Care Agency D were present. However, carers may have rationalised the interactions between Ella and Sean as two people with mental health needs struggling in their relationship, rather than as domestic abuse. There is a tendency amongst health and care professionals to "psychologise" personal and interpersonal difficulties and to accept these as an inevitable consequence of caring roles (Maple et al, 2024; Hopkinson et al, 1998). It is also

possible that carers find themselves in circumstances where they may feel intimidated themselves and consequently do not feel able to report or intervene.

16.11 Response to the risk of domestic abuse and violence

16.12 This includes the recognition and response to domestic abuse and the management of Sean as an alleged offender.

16.13 Sean had not come to the attention of the police until after he became Ella's intimate partner. He had no previous convictions or warnings. There was, therefore, no information about Sean for the police to disclose to Ella under the "Right to Know" as part of the DVDS (Domestic Violence Disclosure Scheme, commonly referred to as Clare's Law – see Appendix A)

16.14 In April 2017 Ella was referred to a MARAC by SaTH on the basis of professional judgment, even though the DASH score was only two. This was good practice and was in accordance the policy protocol, which highlights the need to use professional judgement rather than rely on DASH scores. See Appendix B for information about the Multi-Agency Risk Assessment Conference (MARAC) in Shropshire and the criteria for referrals to the MARAC.

16.15 SaTH stated that it explored domestic abuse with Ella and that during the 2020 Covid-19 epidemic, opportunities to speak with Ella alone were taken, but that she made no disclosures.

16.16 Response to Ella's undressed appearance and her comment to members of Shropshire Council's Housing Department that [Sean] had taken her clothes, on 14th March 2017

16.17 Housing raised a safeguarding concern with ASC on 14th March 2017 when Ella said that Sean had taken her clothes. The concern mentioned Sean's controlling behaviour, that Ella appeared unwell, was self-neglecting and her home was not fit for habitation.

16.18 ASC opened a safeguarding enquiry on 20th March 2017 but, as the social work team would continue to work with Ella, the enquiry was closed. It does not appear that further information was gathered from Housing. It is not clear how the social work team were to address the allegations made in the safeguarding referral from housing, other than by weekly visits to Ella and Sean.

16.19 ASC and West Mercia Police, (Safer Neighbourhood Team) completed joint weekly visits, with additional safe and well checks completed by West Mercia Police. During this Review, ASC stated that these visits proved to be unsuccessful and that Ella refused to speak to both ASC and police officers. Ella's alcohol intoxication was felt to be a contributing factor in this. Contact with Ella was finally established on 28th April 2017.

- 16.20 **Response to possible neglect of Ella by Sean by not calling for medical attention when Ella was unwell in April 2017, and by being reluctant to allow agencies access to Ella.**
- 16.21 On 28th April 2017 Housing and ASC made a joint visit to Sean and Ella. They chose a day when they knew Sean did not work in order to speak to him directly about missing details in his homelessness application. Sean said that Ella was not there. The ASC representative persisted and persuaded Sean to allow her to see Ella. Ella was very ill and her skin was yellow, consequently the ASC representative called an ambulance and ensured Ella was taken to hospital for treatment. The joint working between Housing and ASC was good practice and resulted in a positive outcome. However, it is not clear to what degree ASC recognised this incident as possible neglect of Ella and what steps, if any, it took to prevent similar neglect in the future. It is also unclear if agencies had considered that Sean may have been seeking to hide Ella from services so that any neglect of Ella would go undetected.
- 16.22 West Mercia Police continued to visit Ella in response to calls from neighbours for the remainder of 2017. After this, apart from periods in hospital and care homes or when Ella received care at home, there were no processes in place to identify any neglect of Ella from December 2017 until March 2020 and then from February 2022 until August 2022 and then from November 2022 onwards.
- 16.23 **Response to allegation of rape(s) and response to allegation of domestic abuse, both reported by Ella in April 2017.**
- 16.24 In April 2017, Ella was admitted to SaTH extremely unwell, delirious from dehydration and alcohol poisoning. On 29th April 2017, SaTH reported to West Mercia Police that Ella had alleged that she had been kidnapped and raped by three men, who she did not identify. According to ASC, however, Ella had instead alleged that she had been raped by Sean. ASC opened a safeguarding enquiry which appears to have been led by West Mercia Police. However, SaTH has no records of the rape disclosure(s) made by Ella.
- 16.25 Following this, police officers attended SaTH on 29th April 2017 to interview Ella. However, Ella was too unwell to speak and made no disclosures. Police officers decided to visit Ella the next day when they might be able to obtain further information from her. According to ASC, Ella was deemed not to have the capacity to be interviewed by the police.
- 16.26 The following day, Ella told police officers from the domestic abuse unit that she was afraid of Sean, who was very controlling. Ella said that Sean did not allow her to see her friend, and that Sean had hit her and had attempted to sexually assault her. Ella said that she wanted to complain about Sean's behaviour towards her. Police officers decided to allow Ella to rest and receive further treatment before returning to gather more information from her. They completed a DASH risk assessment and assessed Ella as at medium risk.

- 16.27 West Mercia Police considered the use of a Domestic Violence Protection Notice (DVPN). However, since Ella was being “safeguarded” at SaTH and hospital staff would not allow Sean onto the hospital ward, police officers felt that a DVPN was not appropriate or necessary. However, during the course of this Review some practitioners commented that victims of abuse are not necessarily safe in hospital.
- 16.28 Once Ella was deemed to have capacity by a hospital consultant, she was interviewed by West Mercia Police whilst in hospital on 2nd June 2017. At the time of the interview Ella had successfully undergone an alcohol detoxification programme. As measures were in place to prevent Sean from visiting Ella whilst in hospital the police officers felt the interview was conducted in a supported environment free from undue pressures from Sean’s influence and control. However, Ella did not recall the allegation she had made that she had been kidnapped and raped. Ella was shocked that she had made such an allegation. Ella explained that historically she had been sexually abused as a child and had been raped while married (details of this and who the rapist was are not known by West Mercia Police), but she and her husband had decided not to report it. There was no evidence of recent sexual assault and West Mercia Police did not pursue the matter any further.
- 16.29 West Mercia Police spoke with Ella about her allegation of domestic abuse. This included that Sean was very controlling; would not let her see her friend and had previously hit her and had attempted to sexually assault her. During the conversation, Ella referred to Sean being jealous of her friend, with whom Ella implied that she was also in an intimate relationship with. Ella did not agree that she had been sexually assaulted and said that it had been consensual. West Mercia Police took no further action and did not record a separate crime report for this domestic abuse allegation.
- 16.30 Instead, the police recorded the domestic abuse allegation within the rape allegation report. Had the domestic abuse allegation been recorded separately, it would have had a prominence of its own, which may have helped to identify any patterns of concerning or escalating behaviour. A separate report may also have alerted other organisations to be aware of, and be watchful for, signs of potential domestic abuse, to have guided their actions and prompted them to make referrals (for example, a MARAC referral) as appropriate. Police should record crimes in accordance with Home Office Crime Recording Rules, but it appears that in this instance these requirements were not followed.
- 16.31 **Response to the allegation that Sean was keeping Ella drunk to prevent her from leaving him**
- 16.32 On 2nd May 2017 Ella told police officers that she had attempted to leave Sean numerous times that year. There does not appear to have been any response to this to find out why she had not left Sean and whether she was coerced into staying. Ella told an assessing clinician from the RAID team that Sean kept her drunk to stop her from leaving him. It is not clear whether this was reported to West Mercia Police and it does not appear to have been investigated.

- 16.33 **Responses to arguments and “emotional domestic abuse incidents” between Sean and Ella.**
- 16.34 In 2016 West Mercia Police placed a “Gazetteer” warning on Ella’s address to ensure an immediate response to calls.
- 16.35 From June to December 2017 there were eight incidents/emotional domestic abuse incidents, recorded by the police in relation to Ella and Sean. These were usually at night and on many of these occasions both Ella and Sean were intoxicated, which appeared to be the catalyst for altercations between them. On most of these occasions police were alerted by neighbours who could hear shouting from Ella and Sean. Neighbours commented that the noise from Ella and Sean quietened as soon as the police arrived, but would rise again when the police left. Ella refused help from external domestic abuse services and both Sean and Ella refused referrals to alcohol misuse services in 2017 and 2018. On one occasion, however, Ella was arrested for being drunk and disorderly and taken into custody, and whilst there, she requested alcohol support. The police referred Ella for this, but it appears that Ella did not engage with the alcohol service at this stage.
- 16.36 On these eight occasions between June and December 2017 the police were unable to identify that any crime had been committed (with the possible exception of being drunk and disorderly). The altercations appeared to be arguments between Ella and Sean with no indication of claims of coercion and control. Sean was frequently present or in the background when police officers attended. This may have made disclosure by Ella difficult. It is not clear whether police spoke to Ella and Sean separately on each of these occasions. It would have been good practice to do so, as it provides space, free of immediate pressure, for disclosures about coercion and control. Police officers sometimes suggested that either Ella or Sean go to a different address or sleep in separate rooms until the morning to avoid further confrontations.
- 16.37 In reports of domestic abuse, it can be difficult to distinguish between victims and perpetrators, especially when alcohol induced arguments are involved. Further exploration may be required to distinguish between the initiation of abuse and retaliation. However, a video circulating amongst Sean’s work colleagues which was purported to show Ella abusing Sean, was not investigated by West Mercia Police.
- 16.38 Seven of the eight altercations between Ella and Sean were reported to the police by neighbours. Police officers attending did not always speak to the neighbours, nor were general house to house enquiries made to establish if further information and / or witnesses to the altercations could be identified.
- 16.39 On 6th August 2017, Ella telephoned for the police in the early hours of the morning following a dispute with Sean about watching a film. This was unusual since the other seven calls during this period had been made by neighbours. Police officers spent 15 hours attempting to contact Ella, before finally speaking to her later the same day. West Mercia Police identified during this Review that Ella’s telephone call

suggested that she had some trust in the police to act and, if contact had been made with Ella, this might have prompted further disclosure.

- 16.40 Police did not always attend the scene immediately when called to altercations between Ella and Sean. For example, on 23rd July 2017 the police did not respond to a call from a neighbour until the following day because of other commitments. Given the history of domestic abuse, the RMP and the “Gazetteer” warning on the address, West Mercia Police has recognised that the call could have been reprioritised.
- 16.41 DASH risk assessments were not always completed. When they were completed, DASH assessments were usually made for both Ella and Sean. Rather than completing two DASH risk assessments, more emphasis could have been placed on separating out and identifying the perpetrator from the victim, if this had been unclear. Ella and Sean sometimes refused to answer the questions in the DASH risk assessment, and so police officers completed the assessments based on Ella and Sean’s domestic history and their own observations. This was good practice. On one occasion, however, police officers did not complete a DASH risk assessment because it was judged that Ella and Sean were too intoxicated to answer questions. West Mercia Police has concluded that DASH questions should be asked even if victims are intoxicated. The intoxication of the perpetrator is also not a barrier to completing a DASH assessment for a victim. If the DASH is declined, officers should make an informed risk assessment based on their own observations. This learning point is covered in an Investigating Domestic Abuse course which is subsequently being delivered to all front line police officers at West Mercia Police.
- 16.42 On 16th September 2017 police officers referred Ella to the Harm Assessment Unit (HAU). Following a Domestic Abuse Triage meeting on 18th September 2017, West Mercia Police made a referral to ASC. However, there is no record that this was received by ASC. West Mercia Police is not routinely informed of the outcomes its referrals so did not query the absence of a follow up by ASC.
- 16.43 On 30th October 2017, Housing sent a final warning letter to Sean for anti-social behaviour. It is not clear if this was related to disturbance caused by Ella and Sean’s arguments. This may, however, have been a way of disrupting any pattern of domestic abuse that had been occurring between Sean and Ella, as well as seeking to stop the disturbance to neighbours.
- 16.44 On 21st December 2017 the police closed the RMP as there had not been any reports of “domestic emotional” incidents in the previous three months. The decision to close the RMP was subject to review should there be any further reports of domestic incidents. However, there was another incident on 23rd December 2017, but police did not reopen the RMP.
- 16.45 The dynamics of abuse may have been obscured by a focus on alcohol misuse, the mutual vulnerability of both Ella and Sean and on incident-based responses. The lack of identification of who was causing harm in the eight “domestic emotional”

incidents reduced perpetrator accountability and may have meant that interventions did not fully reflect the nature, seriousness and cumulative impact of abuse.

- 16.46 **Response to traumatic subdural haematoma and agencies' understanding of how this occurred.**
- 16.47 In February 2018 Ella suffered a seizure and was taken to SaTH by WMAS. WMAS identified in hindsight that the crew could have made a referral to ASC as it was evident that Ella had care and support needs.
- 16.48 At SaTH Ella had a CT head scan which indicated traumatic subdural haematoma. This is a blood clot that forms between the brain and the skull after a head injury. SaTH was aware that there was a past history of domestic abuse in Ella's life and against this background both nursing and medical staff attempted to explore her current condition as it may have been caused by domestic abuse. They asked Ella how she thought she had acquired the head injury which led to subdural haematoma. This was good practice. Ella, however, said that she could not remember and had felt unwell at home and woken up in hospital. SaTH noted that Ella had attended the emergency department on 26th December 2017 with a head injury, which Ella attributed to a fall whilst intoxicated.
- 16.49 Ella was transferred from SaTH to RSUH on 5th February 2018. SaTH advised RSUH of concerns of past domestic abuse and that it had recently made a safeguarding referral because Sean was unable to provide a full history of Ella's presenting complaint. It appears, however, that no safeguarding referral to ASC had been made. Given Ella's already established background of domestic abuse, this may also have been an opportunity for SaTH to have notified West Mercia Police of what it believed at the time to be subdural haematoma caused by a head injury.
- 16.50 During an operation for haematoma, RSUH established that Ella did not have haematoma, but instead a subdural empyema. It was extremely unlikely that this would have been caused by a head injury. Nor was the empyema caused by alcohol withdrawal as Ella had suggested to alcohol support services, over a year later. Subdural empyema is caused by the spread of infection from nearby areas, such as the sinuses, or infection from a penetrative head wound or infection introduced from head surgery. There was no evidence of a penetrative head wound to Ella and the infection was found during surgery. Consequently, the infection was present before surgery but it was extremely unlikely that Ella's empyema was caused by domestic abuse.
- 16.51 Throughout her time at RSUH Ella was acutely unwell and confused and she did not disclose domestic abuse. Neither did RSUH explore domestic abuse with Ella because of its policy to wait until patients have recovered or have been medically optimised, so that accurate information can be obtained from them.

- 16.52 RSUH noted that Ella had experienced domestic abuse in its 28th February 2018 discharge summary to Ella's current GP. The GP practice did not see or attempt to contact Ella once she was out of hospital, and therefore did not raise or explore domestic abuse with her.
- 16.53 Further exploration of Sean's inability to account for the events that led to Ella's admission to hospital, such as a referral to ASC (which it appears was not made) may have facilitated further enquiry into Ella's life and her relationship with Sean. In addition, Sean's suitability and ability as a carer for Ella may have been considered at an earlier stage. As a result of Ella's empyema, Ella experienced weakness in the left side of her body resulting in mobility difficulties and incontinence. A "therapies review", completed on 27th February 2018 whilst Ella was at RSUH, suggested that Ella could benefit from a "social review and functioning assessment". Ella was discharged from Royal Stoke University Hospital to Royal Shrewsbury Hospital on 28th February 2018 for rehabilitation. On 20th March 2018, prior to discharge from hospital, ASC considered a refuge for Ella, but she refused saying that her and Sean were "practically married" and no one could keep them apart. Ella said she wanted to be with Sean and her cats.
- 16.54 West Mercia Police noted that reports of domestic abuse of Ella reduced significantly from 2018 onwards. Given that Ella had developed mobility difficulties, more consideration may have been given to Ella's ability to contact the police if in danger or when experiencing coercion, control abuse or neglect. Ella had told police officers that she did not have a mobile telephone and in 2017 West Mercia Police had established a neighbour as a contact for Ella instead. However, Ella had since moved and in 2018 no longer lived near this neighbour. Consequently, from 2018 onwards, it appears that Ella had reduced ability to contact help independently.
- 16.55 **Responses to injuries**
- 16.56 On 4th January 2019, Ella attended the emergency department at SaTH with an injury to her left wrist. SaTH noted that Ella had a history of falls, but that there were no other indicators of abuse. It is unclear whether there were any specific enquiries made about the cause of this injury. On 9th October 2019 Ella sustained a further fracture to her left wrist. Ella explained that she was out with Sean and fell whilst getting into a car. At this time a social care practitioner commented to Ella that accidents seem to happen when she was in the company of Sean, but Ella was firm that this was an accident and denied any abuse. It was good practice for SaTH to question the source of Ella's injury. On 4th December 2021 Ella sustained a soft tissue injury again to her left wrist. SaTH completed a safeguarding screening tool and Ella told the hospital that she had fallen while intoxicated.
- 16.57 On 24th April 2022 Ella sustained a soft tissue injury to her leg. The WMAS report stated that Ella fell whilst transferring from her commode to her bed. It does not appear that this explanation was questioned by the ambulance crew or by SaTH.

- 16.58 In summary, Ella sustained several injuries. Whilst further enquiry was sometimes made about the circumstances in which the injuries were acquired, Ella often provided plausible explanations for them. Ella's alcohol consumption and a brain injury may have increased her risk of falls, but it may also have increased her vulnerability to physical abuse that might result in falls. Lessons from other DHRs point to the need to look beyond immediate explanations for injuries especially when there is already a history of domestic abuse.
- 16.59 **Response to possible economic abuse**
- 16.60 There was a general lack of awareness of the possibility that Ella was being financially abused. For example, Care Agency D, SaTH, West Mercia Police and MPFT were unaware of the possibility of Ella experiencing financial or economic abuse.
- 16.61 On 12th July 2019 the care home where Ella was living at the time (accommodation 12), notified Housing that money had been taken out of Ella's bank account without Ella's permission. Housing referred this concern to ASC, which visited Ella that day. Ella did not know where the money had gone and it became apparent that she was unclear about the benefits she received. ASC clarified this with the DWP, which stated that Ella's benefits had stopped in December 2018 but could not explain why. Ella was clear that she had not given permission to anyone to withdraw money from her account. However, Sean knew the PIN number for her bank card and the bank would not cover the loss. The police were not notified of this incident and therefore were not involved.
- 16.62 Sean was asked to bring Ella's bank statements to Accommodation 12 so that the care home manager could check the activity in Ella's account. However, Sean brought his own bank statements, not Ella's. On further investigation, the DWP clarified that Ella had not attended a medical assessment in February 2019 and her benefits, in accordance with DWP policy, had been stopped. Ella's benefits were subsequently restarted. Whilst this was a positive outcome, there does not appear to have been any further enquiry into whether the concerns about unauthorised access to Ella's bank account were fully explained by the temporary pause in the receipt of benefits. In addition, Sean had Ella's pin number and whilst he may have mistakenly brought his own rather than Ella's bank statements to be checked, this may not have been accidental and may have been an example of Sean's ability to control Ella.
- 16.63 In May 2019 when Ella was living in a hotel, there were reports that other residents were taking Ella's belongings and that some were providing care for Ella and paying themselves out of Ella's money.
- 16.64 In addition, on 28th May 2019 WMAS made a safeguarding referral to ASC because Ella was self-neglecting and another resident at the hotel had gone into Ella's room and taken Ella's money and belongings. It is not clear what, if any, action was taken about this safeguarding referral.
- 16.65 **Responses to refusal to accept care calls**

- 16.66 Despite concerns in February 2021 that Ella consistently cancelled some of the care visits she received each day, Ella's care package remained in place until February 2022. However, there was then a delay until August 2022 before a new care provider, Care Agency D was found.
- 16.67 Care Agency D visited Ella twice a day to provide care for her. However, after the first few weeks, both Sean and Ella began to refuse care calls, turn carers away and removed the door key from the key safe. Ella would occasionally accept help with her personal care when the carers persisted, but most of the time she refused help.
- 16.68 Care Agency D raised concerns with ASC and supplied multiple photographs of the poor conditions in the property. Ella told ASC that Sean had quit his job and would be able to care for her full time from November 2022. Consequently, the care package with Care Agency D was stopped on 2nd November 2022. At the time, consideration does not appear to have been given to Sean's ability to care for Ella. In hindsight, however, ASC recognised that from descriptions of the property it was evident that the arrangement for Sean to care for Ella was not meeting Ella's support needs. There had already been warning signs in 2017 and 2018 that Sean may be neglecting Ella and that Sean had needs of his own, including alcohol dependency. Despite being recognised as Ella's carer and to have needs of his own, Sean was not offered a s10 Care Act 2014 carer's assessment or a s9 Care Act 2014 assessment of need.
- 16.69 There also does not appear to have been consideration of the possibility that Ella was being controlled or coerced by Sean into refusing visits from Care Agency D in order to prevent her access to a source of help or to prevent abuse being witnessed.
- 16.70 From February 2018 Ella's mobility reduced considerably. There were reports that Ella's bedding at home, and at the hotel were soiled (ASC IMR 24th May 2019). This suggested that Ella's personal care was neglected during periods when she was not receiving agency care calls. In addition, Ella and Sean often turned the care workers away, and this resulted in neglect and self-neglect going unchecked.
- 16.71 ASC has recognised during this Review that it was evident that ASC staff took what Ella said at face value and, despite Ella maintaining that Sean was supporting her, this was clearly not the case.
- 16.72 **When Ella disclosed domestic abuse how did agencies respond to Ella's statement she had no option other than to return to Sean?**
- 16.73 It does not appear that there is any evidence that Ella told to agencies that she had no option other than to return to Sean. West Mercia Police offered Ella assistance, but she declined, and when she left hospital in June 2017, Ella returned to Sean despite him having his own separate accommodation.
- 16.74 **Was Ella's heightened vulnerability owing to her physical health considered as part of the risk assessment?**

- 16.75 Ella's physical health had deteriorated considerably following her subdural empyema in 2018. A CT scan showed that Ella had suffered a stroke on the right side of her brain and Ella was left with left side weakness and incontinence. A stroke affecting the right side of the brain often leads to impairments on the left side of the body. Ella could walk and manoeuvre from sitting to standing only with the aid of a quad walking stick. Ella also had contractures in her left arm, which could indicate a permanent shortening of her muscles.
- 16.76 Ella's physical health needs were considered in, and responded to, by, for example, the offer of temporary accommodation to Ella by Housing and by Care Agency D (Care home staff) in its provision of support to Ella. However, Care Agency D commented that although Ella required physical help, she was "very clear about what she would and would not do". It is not apparent from this statement whether Ella was clear about the help she needed or about what she could and could not do. ASC commented that it cannot find evidence that Ella's heightened vulnerability due to her physical health needs was considered as part of its risk assessment for Ella's support needs.
- 16.77 West Mercia Police, use the THRIVE formula (threat, harm, risk, investigation, vulnerability, engagement) as part of its risk assessment and were aware of Ella's vulnerability due to her physical health needs and alcohol dependence in the RMP, which was closed in December 2017. In February 2018, when Ella's physical health declined considerably as a result of her subdural empyema and stroke, the likelihood of emotional abuse and other forms of coercion and control may have increased Ella's dependence on Sean. Additionally, Ella's immobility is likely to have made it more difficult for Ella protect herself. Ella might also have been less able to report abuse or neglect because she did not have a mobile telephone. Despite these changes to Ella's mobility, the RMP was not reopened and between 31st January 2017 and 7th October 2022 Ella was not seen by West Mercia Police. Given the circumstances and history it may have been appropriate to have reinstated the RMP and to have checked on Ella's welfare periodically.
- 16.78 West Mercia Police commented, however, that in order to re-instate the RMP, there would need to be further reports of abuse, or information from another agency to suggest that the risk of abuse has greatly increased. Ella would also need to agree to the RMP and to activities such as a Crime Risk Survey, Fire Referral, Safer Neighbourhood Team Visits and contact with a Domestic Abuse Risk Officer. West Mercia Police has also commented that the arrangements for discharge from hospital could also have included consideration of Ella's ability to contact the police if needed. A further MARAC referral could have been considered instead.
- 16.79 **Given Ella's stroke and seizures did she have the mental capacity to make her own decisions on future living arrangements?**
- 16.80 The Mental Capacity Act sets out the criteria by, and the order in which, a person's mental capacity should be assessed as follows:

- 16.81 Is the person unable to make a decision? i.e. are they unable to do at least one of the following things:
- understand information about the decision to be made, or
 - retain information in their mind, or
 - use or weigh information as part of the decision-making process or
 - communicate their decision (by talking, using sign language or any other means).
- 16.82 Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?
- 16.83 Does the impairment or disturbance mean that the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions, but have the capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.
- 16.84 The critical decisions that Ella needed to make about her future living arrangements included where she lived and with whom and also how her care and support needs could best be met, to keep herself safe. Care Agency D concluded that Ella could understand, retain and use information to make decisions about her future living arrangements but that she sometimes made unwise decisions. However, Ella's mental capacity to make decisions about living with, and being cared for by, Sean, and to refuse care were not considered by practitioners. Instead, Ella's mental capacity to be interviewed by police officers and her capacity to refuse medical treatment were considered.
- 16.85 The first principle of the Mental Capacity Act 2005 is that a person's capacity should be assumed unless proven otherwise. The third principle of the Act is that a person is not to be treated as lacking capacity merely because they have made an unwise decision. This does not mean that the Mental Capacity Act 2005 gives people the right to make unwise decisions but instead that making one unwise decision is insufficient evidence for a lack of mental capacity. However, a series of similar decisions with harmful consequences may suggest a lack of mental capacity and indicate that an assessment of capacity is appropriate. It appears that Ella made a series of unwise decisions about refusing care from two care providers (at two different times), about living with and returning to live with Sean and relying on Sean to be her carer, despite evidence that this may be detrimental to her health and wellbeing.
- 16.86 The Mental Capacity Act 2005 applies to people who have "an impairment of, or a disturbance in the functioning of, the mind or brain". Factors which may result in an impairment to the functioning of the mind or brain include:
- Head injuries (from impact).
 - Korsakoff's syndrome, which is a chronic memory disorder often caused by severe thiamine deficiency.
 - Hepatic encephalopathy.

- Strokes.
- Seizures.
- Borderline personality disorder/ Emotionally Unstable Personality Disorder.
- Traumatic experiences including those experienced in adulthood as well as childhood.

16.87 All of these factors were present for Ella as follows:

16.88 **Head Injury**

16.89 In the period covered by this Review it appears that Ella suffered at least one head injury. This was in December 2017 and was described as minor and due to a fall while intoxicated.

16.90 **Korsakoff's Syndrome**

16.91 Korsakoff's syndrome is caused by severe thiamine deficiency often due to chronic alcohol use and is characterised by severe memory problems, amnesia and confabulation (making up memories to fill gaps). In May 2017 a RAID team consultant could find no evidence that Ella had Korsakoff's syndrome. Although Ella had stopped drinking alcohol in June 2019, there was concern that Ella had started again in February 2021. In 2023 empty alcohol bottles were reported in Ella and Sean's home, and a practitioner had witnessed Ella asking Sean for alcohol. If Ella had started drinking again, especially in the context of falls, there was a risk that she might develop Korsakoff's syndrome. In 2022, when Ella was in the Community Hospital, Ella's impaired memory was noted, but it is not clear if Ella presented any of the specific symptoms of Korsakoff's syndrome. It appears, therefore, that between May 2017 and 2023, when Ella died, Korsakoff's syndrome was not reconsidered.

16.92 **Hepatic encephalopathy**

16.93 Ella was treated for hepatic encephalopathy while in hospital in May 2017 but did not remain abstinent of alcohol. Hepatic encephalopathy is distinct from Korsakoff's syndrome and is characterised by confusion, drowsiness, personality changes and 'in severe cases' seizures and coma. It results from the liver's inability to filter toxins from the blood leading to a buildup of these toxins in the brain. Hepatic encephalopathy can be a complication of liver disease including alcoholic liver disease.

16.94 **Stroke**

16.95 Ella was admitted to SaTH with a stroke in September 2018 and the hospital believed that she may have also had a stroke two weeks prior to her admission. Alcohol use can increase the risk of stroke and alcoholic liver damage, can prevent the liver from producing substances that help blood to clot, leading to an increased risk of [stroke](#) caused by bleeding in the brain. Despite the risk that a stroke can lead to a loss of mental capacity, this does not appear to have been assessed.

16.96 Seizures

16.97 While brief, isolated seizures are unlikely to cause permanent brain damage, frequent back-to-back or prolonged seizures can cause permanent damage. This may lead to cognitive impairments and problems with memory. Ella was noted to have seizures with some regularity and increases in frequency were recorded by agencies in 2018, 2019, and 2020. In 2022 SaTH noted that Ella had up to eight seizures a day, likely caused by alcohol withdrawal and non-compliance with medication. It is not known to what degree the seizures caused permanent damage or prolonged mental incapacity, but they could have been a factor in considering Ella's capacity to make decisions about, for example, keeping herself safe. SaTH commented that a person would not have mental capacity during a seizure, but SaTH would not assume that a person had lost capacity globally due to seizure activity. There was no evidence of status epilepticus (a seizure lasting more than five minutes) in Ella's case.

16.98 Borderline personality disorder

16.99 In August 2017 a health worker who visited Ella while she was in police custody, recorded that Ella had borderline personality disorder (BPD). Research suggests that BPD is associated with impairments of brain functioning, particularly in areas related to emotional regulation, impulse control and executive functioning.

16.100 Adverse Childhood Experiences and Trauma in Adulthood

16.101 Ella was abused as a child and had experiences in adulthood that were likely to be traumatic.

16.102 When Ella was assessed for Korsakoff's syndrome in May 2017 the clinician advised that Ella was in an acute "emotional situation" and lacked mental capacity, but this would be regained when Ella was calm.

16.103 There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

- 16.104 As a result, people with frontal lobe damage caused by traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.
- 16.105 In summary, Ella had a history of alcohol related brain injury, one head injury, borderline personality disorder, adverse childhood experiences and experience of trauma in adulthood. Ella had suffered at least one stroke and had frequent seizures. Consequently, Ella could be considered to have an impairment, or disturbance, in the functioning of her mind or brain, which may have impacted on her ability to make decisions. SaTH commented that its notes confirmed that Ella had the mental capacity to make health decisions and that there were no documented concerns about her capacity. SaTH does not undertake mental capacity assessments unless there is a reason to think that the person may not be able to make a decision for themselves.
- 16.106 If Ella had been found to lack the capacity to make decisions it would have provided the opportunity to have made decisions in her Best Interest and if, as was likely, Ella opposed these, to instruct an Independent Mental Capacity Advocate (IMCA) to represent her and to seek determination by the Court of Protection. There is no certainty that approaches like this would have been successful, but they may have provided a way of disrupting the cycle of coercion and control, refusal of outside help, and neglect and self-neglect.
- 16.107 SCHO stated that a request was made for a mental capacity assessment on 21st May 2022 because there was concern about Ella's decision making. A mini Addenbrookes Cognitive Assessment was undertaken and Ella scored 25 out of 30. Consequently, Ella was not within the range for a diagnosis of dementia or mild dementia. However, the mini Addenbrookes Cognitive Assessment is not an assessment of the mental capacity to make a specific decision at a specific time.
- 16.108 Assessing mental capacity to make a specific decision can take time and the use of mental capacity assessments in domestic abuse appears to be underdeveloped but guidance is beginning to be developed (for example, [Dartington Trust \(2022\)](#) Dartington Trust (2022).
- 16.109 **How was Sean managing financially after he finished work in November 2022 – was there any evidence of economic abuse?**
- 16.110 It was known that Sean had received a lump sum from the sale of the house that he had owned with his sister, but it appears there was no knowledge of how Sean was managing financially in November 2022. There was no evidence that Sean was economically abusing Ella. However, there could have been further enquiry into concerns of unauthorised access to Ella's bank account and the reasons why Sean brought his own rather than Ella's bank statements to the care home manager, who was seeking to check the activity on Ella's account.

- 16.111 ASC noted that in February 2022, Sean was staying with Ella more permanently and was thinking of becoming her paid carer. An ASC practitioner told Ella and Sean that this was not feasible due to Sean living in the property with Ella.
- 16.112 Although possibly not connected to Sean, there were other instances of possible economic abuse of Ella by others. It appears that no enquiries were made about the allegation that some residents of the hotel in which Ella was staying provided care for Ella and paid themselves out of her money, and took her belongings. A safeguarding referral made by WMAS, which also highlighting possible economic abuse of Ella by other residents, does not appear to have been actioned or followed up. No concerns of potential economic abuse were reported to West Mercia Police.
- 16.113 Agencies working together to protect Ella**
- 16.114 There was evidence that agencies worked together to support and protect Ella. For example, during 2017 Housing, West Mercia Police and ASC made joint visits to Ella and Sean. A joint visit between ASC and Housing in April 2017 resulted in Ella being taken to hospital. It is not known what may have happened had Ella not received acute care at this time.
- 16.115 There was also information sharing. For example, WMAS made three safeguarding referrals as well as notifying Ella's GP when attending to Ella at home. West Mercia Police also contacted GP surgery D to perform lateral checks when Ella was found by WMAS on 18th December 2023. However, GP surgery D commented that there could have been more information sharing about Ella. It had received only one call contact from ASC social care in February 2021. The GP practice was not informed who was providing care to Ella, nor when the care package ended.
- 16.116 SaTH made referrals to ASC, including raising two safeguarding concerns. SaTH commented as part of this Review that to support discharge planning there was relevant MDT input throughout each of Ella's admissions to hospital. Care Agency D also raised repeated concerns with ASC, including a request to clean Ella and Sean's accommodation, but this was not done.
- 16.117 MPFT also commented that its clinical records indicated good information sharing with agencies and appropriate review and assessment by mental health services. However, this may have been strengthened by a multi-disciplinary meeting. ASC also commented on the absence of multi-disciplinary team meetings between agencies. Multi Agency Risk Management Conference (MARAC) referrals, however, were made in November 2016, April 2017 and June 2017. An adult safeguarding strategy meeting was also held by ASC on 18th March 2023 with West Mercia Police at which it was agreed that police officers were to share the contact numbers for the Crisis team with Sean should he require its support. A referral to ASC and Housing was also to be made. It is not clear whether these referrals were ever made or indeed what the referrals were for.

- 16.118 There were a number of occasions when an agency stated that it had sent referrals or concerns to ASC, but these do not appear to have been received. For example, referrals on 16th September 2017 from a domestic abuse triage meeting. It may be appropriate for ASC and referring agencies to review their practice for safeguarding concerns to ensure that it is clear how and to where safeguarding concerns should be raised and that ASC has a robust system for picking up on concerns and actioning them appropriately. SaTH commented that practice in this area has improved significantly since 2017.
- 16.119 **Self-neglect and care and support needs assessments and provision.**
- 16.120 On 17th February 2017 West Mercia Police officers were called by neighbours as Ella was lying in the road outside Sean's house and she was in danger of being run over. Police attended and found all the windows to the house were smashed, with no heating or running water in the property. Rubbish and human waste scattered on the driveway and within the house itself. Ella was intoxicated and there were 11 cats in her home. Police officers sent a crime report of a vulnerable adult incident to the HAU (Harm Assessment Unit) and noted that the property Ella and Sean were living in was almost derelict, with no heating or water, there was rubbish and human waste scattered about, and both Ella and Sean were alcohol dependant. The HAU concluded that the incident was due to alcohol misuse and that Ella had the capacity to choose and accept the risks of her "lifestyle". No referral was made to ASC since Ella did not meet the definition of a vulnerable adult.
- 16.121 During 2017 West Mercia Police referred to Ella's "lifestyle choice" in its records. For example, on 21st February 2017, Ella was noted by police officers to have the mental capacity to choose and accept the risks associated with her lifestyle choice. On 3rd May 2017, Ella's lifestyle choice was noted to have a significant impact on her health and mental health, such that she did not have capacity to act in her own best interests. On 21st December 2017, Ella was recorded to have refused assistance and to have chosen to continue her lifestyle out of her own free will.
- 16.122 Ella told police officers that she made bad choices with relationships and was referred to The Freedom Programme. Police officers explained to Ella that The Freedom Programme would help Ella to build on her expectations of relationships and assist her with making better future decisions. However, police officers identified that Ella's "lifestyle" meant that she was not always able to make "right and safe decisions".
- 16.123 However, given Ella's history of adverse childhood experiences (ACEs), alcohol dependency and history of abusive relationships, the concept of lifestyle choice might be misleading. Ella had experienced sexual abuse as a child and her mother had not been affectionate towards her. There are strong evidential, as well as logical and intuitive links between trauma in childhood, and the experience in adulthood of mental ill health, excessive use of drugs and/ or alcohol, self-neglect, chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield et al, 2025). Traumatic events in childhood are often referred to, somewhat

euphemistically since the term barely captures their extremely disturbing nature, as Adverse Childhood Experiences (ACE) (Felitti et al, 1998).

- 16.124 ACEs include growing up in a household with someone who has mental health needs, misuses substances, or has been involved in the criminal justice system. They include exposure to child maltreatment or domestic violence, witnessing traumatic events and also losing a parent through divorce, separation or death (WHO, 2012). People who have experienced traumatic events can feel more easily threatened or “triggered” in a range of settings including ones where no obvious threat is present (Donohoe, 2022). This can make exploring domestic abuse more challenging and might prompt disengagement and avoidance.
- 16.125 The impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. There is also considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them. Ella appeared to deny that she was at risk from Sean, but it is unknown whether any of these denials were made under duress.
- 16.126 The impact of exposure to ACEs should not, however, be considered too deterministically. Many people who have faced ACEs become well-adjusted and successful adults. Understanding the impact of ACEs can, however, help in formulating responses and interventions to support people who have experienced them.
- 16.127 Trauma-informed approaches to engaging with Ella might have been helpful. These include flexibility of means and times of contact; using strength-based approaches that built relationships on the basis of what Ella enjoyed doing; using incentives to reward engagement; using assertive approaches rather than signposting and expectations that Ella would self-refer and making the most of the “window of tolerance” when Ella was most able to engage. Ella was asked to self-refer to With You.
- 16.128 These trauma informed approaches are, however, not guaranteed to work and may have been tried by different agencies. Care and support needs assessments determined that Ella required support with personal care, meal and drink preparation, managing medication and support to manage her environment/accommodation, finances and budgeting. From 22nd August 2022 Care Agency D were engaged to provide personal care and medication prompts. It appears therefore that that Care Agency D were not contracted to provide support to Ella in managing her environment, nor with managing her finances. The new care package did not include meal preparation and also changed the timing of the visits. Sean was listed as Ella’s carer from 27th March 2019.
- 16.129 Signs of self-neglect by, and the possible neglect of, Ella were evident from the state of the homes in which Ella and Sean lived. Neglect or self-neglect were also evident at Sean’s property in 2017 before it was sold at auction and at Ella’s home from March

2020. This property had originally been intended for Ella only, but Sean spent an increasing amount of time there.

- 16.130 Ella told practitioners that Sean was her carer and the last time a care visit was made by Care Agency D was on 2nd November 2022. Care Agency D provided ASC with photographs of the condition of the property. Six months passed without a visit to Ella. The next time a practitioner was able to see inside was on 12th May 2023 when the WMAS ambulance crew arrived. The crew noted the house was very untidy with a large quantity of beer cans in the bedroom. The property was visited again on 14th June 2023, this time by officers from West Mercia Police who noted that the property was littered with empty bottles and cans, and then on 2nd August 2023 by the ambulance crew who noted bags of rotten food and a broken bed which was heavily stained. The ambulance crew made a safeguarding referral but no further visit to Ella was made. Subsequently, no practitioner visited for another five and a half months until 18th December 2023, shortly before Ella's death.
- 16.131 It appears that more questions, curiosity and visits from agencies at an earlier stage, such as October / November 2022, may have enabled a reasoned assessment of Sean's ability and willingness to care for Ella and a review of Ella's care needs. It may also have enabled further consideration and assessment of Ella's mental capacity.
- 16.132 On 16th October 2018 Ella's current GP reviewed concerns about Ella's missed neurological appointments and decided no action was required. Ella missed a number of appointments with neurology and the nerve injury clinic, but no action was taken to try to understand why this happened. There are several unknowns at this point including Ella's needs, who was caring for her, was she drinking alcohol, was there anything that contributed to her fall, for example, a neurological deficit, drug/alcohol use, any evidence of domestic abuse. This could have been an opportunity to explore these with Ella. Apart from a spell in SaTH Ella was of no fixed abode at this time which may have affected whether Ella was notified of these appointments.
- 16.133 On 12th May 2023 the wording of the WMAS report was ambiguous and consequently, no action was taken on it by Ella's GP surgery.
- 16.134 A similar situation occurred on 2nd August 2023.

17. Conclusions

- 17.1 The purpose of this Review was to examine:
- 17.2 **Agency awareness of domestic abuse in Ella and Sean's relationship, responses to domestic abuse and how agencies minimised the risk to Ella.**
- 17.3 The presence, and history, of domestic abuse was recognised in the relationship between Ella and Sean by West Mercia Police, ASC, SaTH and RSUH. Housing also became aware of the possibility of abuse when Ella told a Housing representative that Sean had taken her clothes.

- 17.4 Ella appears to have been unwilling to disclose domestic abuse by Sean. Disclosure of domestic abuse is known to be difficult and can put victims at risk and therefore flexibility, support and the creation of a safe environment to enable a person to talk about what is happening to them, are necessary. One of the challenges identified in this DHR was that Sean was sometimes present or in the background when police officers attended. This may have made disclosure by Ella difficult. However, in consultations without Sean present, Ella did not generally disclose domestic abuse even when asked about her relationship with him.
- 17.5 Ella and Sean's use of alcohol may have presented a barrier to the recognition of domestic abuse. Many of the incidents reported to the police were late at night when both Ella and Sean were often under the influence of alcohol. Substance dependency can be a barrier to both disclosure and help seeking for both domestic abuse and also for substance dependency itself.
- 17.6 It is unclear if agencies had recognised that Sean may have been seeking to hide Ella from services so that any neglect or abuse of Ella would go undetected.
- 17.7 **Responses to potential domestic abuse**
- 17.8 Many of the police attendances were in response to Ella and Sean arguing. No criminal offence was disclosed (apart from both being drunk and disorderly). On some occasions the police sought to separate Ella and Sean for the rest of the night to avoid further "emotional outbursts" and altercations. Neither Ella nor Sean would make a complaint against the other and police officers found it difficult to identify one of them as the perpetrator and the other as the victim. More attention could have been given to identifying the perpetrator and the victim, when these roles were unclear, and focusing on how "arguments" started. The dynamics of abuse may have been obscured by a focus on mutual vulnerability, alcohol use and incident-based responses. The failure to identify who was causing harm reduced perpetrator accountability and may have resulted in interventions that did not fully reflect the nature, seriousness and cumulative impact of abuse. Ella may not have fitted the stereotype of a 'perfect victim' (Inzunza, 2022) due to her mental health needs and alcohol use. Victims of domestic abuse with addictions, mental health issues or complex, chaotic lifestyles may be dismissed as being unreliable or even complicit in the abuse they experience.
- 17.9 Further information about Ella and Sean's relationship and other indicators that Ella was a victim of domestic abuse perpetrated by Sean may have been gathered if police officers had interviewed the neighbours who had called the police in response to disturbances involving Ella and Sean. As well as seeking to stop the disturbance to neighbours, the final warning letter sent by Housing to Sean for anti-social behaviour may have been a way of disrupting any pattern of domestic abuse that had been occurring between Sean and Ella.

- 17.10 On one occasion, following an argument between Ella and Sean and a subsequent Domestic Abuse Triage meeting, West Mercia Police made a referral to ASC. However, there is no record that this was received by ASC. West Mercia Police is not routinely informed of the outcomes of its referrals and so did not query the absence of a follow up by ASC. There is a need for feedback from ASC to agencies that make referrals to it (Recommendation 1).
- 17.11 From December 2016 until December 2017, West Mercia Police implemented a Risk Management Plan for Ella and Sean. In cases of domestic abuse, joint action planning can be unsafe where it does not distinguish between the victim's needs and the risks posed by the perpetrator. This can result in victim safety not being sufficiently prioritised and can weaken perpetrator accountability. However, in this case the Risk Management Plan involved visits to Ella and Sean which appear to have been effective. For example, police officers were able to see Ella alone on occasion and one visit led to Ella's admission to SaTH for pneumonia with pulmonary oedema, hepatic encephalopathy, and alcoholic hepatitis.
- 17.12 In April 2017, Ella alleged to hospital staff that she had been raped (it is not entirely clear if this was an allegation of rape by Sean or three men who were unknown to Ella). The investigation of the rape allegation was postponed by West Mercia Police until Ella had the mental capacity to be interviewed. After a month SaTH assessed Ella to have regained capacity. During this time, Ella's safety was considered to have been secured by hospital staff who refused to allow Sean access to Ella's ward. Subsequently the allegation of rape was retracted by Ella, who did not recall making the allegation, and consequently no further action was taken. Ella had made the allegation of rape whilst recovering from delirium and alcohol poisoning.
- 17.13 Although Ella had retracted the allegation of rape, she had also told police officers that she had been abused by Sean who was very controlling, would not allow her to see her friend, had hit her and had attempted to sexually assault her. West Mercia Police did not record a separate crime report for these domestic abuse allegations, which were instead recorded within the rape allegation report. It seems that the dominant allegation of rape overshadowed the other allegations which were also serious (Recommendation 2).
- 17.14 Ella said that Sean was her carer, however there were at two reports that suggested that Sean was not helping Ella with her personal care needs. ASC engaged care agencies to help Ella with personal care and medication prompts. There were gaps in provision and Ella and Sean often turned carers away. Sean was not offered a carer's assessment and his ability and his suitability as a carer was not considered (Recommendation 3).
- 17.15 Care workers did not report any concerns about the domestic abuse of Ella by Sean. There may be barriers to care workers in recognition, reporting and intervening in domestic abuse (Recommendation 4)

- 17.16 Apart from periods in hospital and care homes or when Ella received care at home, there were no processes in place to identify any neglect of Ella for substantial periods of time.
- 17.17 West Mercia Police demonstrated good practice by completing DASH assessments even when Ella and Sean refused to answer the questions. However, DASH assessments were not made when Ella and Sean were intoxicated.
- 17.18 West Mercia Police also demonstrated good practice in 2017 by establishing a neighbour as a contact between Ella and the police. This good practice could have been extended into 2018 after Ella had moved home and experienced the subdural empyema and stroke and subsequently developed care needs. West Mercia Police noted that the number of calls to the police reduced significantly after this point in time. Considering Ella's heightened vulnerability due to mobility difficulties, West Mercia Police might have taken further precautions such as to reinstating the RMP or ensuring that Ella had a means to contact the police to call for help when she needed to. West Mercia Police commented that in order to reinstate the RMP, further reports of abuse, or information from another agency to suggest that the risk of abuse had greatly increased, would have been required. Ella would also have needed to agree to the reinstatement of the RMP. West Mercia Police also commented that the arrangements for discharge from hospital should have included consideration of Ella's ability to contact police if needed. (Recommendation 5)
- 17.19 Ella moved home frequently, with stays in hospital and was for a time homeless and of no fixed abode. Homelessness may have had an impact on Ella's health and wellbeing. It is likely that she did not receive notification of health (neurology) appointments and consequently did not attend them.
- 17.20 There were also examples of incidents that might have led to further enquiry about domestic abuse. For example, when Ella sustained two fractures to her left wrist in quick succession, a social care practitioner commented to Ella that accidents seem to happen when she was in the company of Sean, but Ella insisted they had been accidents. In addition, no concerns of potential economic abuse were reported to West Mercia Police. There appears to be some concerns that other hotel residents and Sean were economically abusing Ella, but these concerns do not appear to have been investigated.
- 17.21 **When Ella disclosed domestic abuse how did agencies respond to Ella saying she had no option other than to return to Sean?**
- 17.22 There is extensive evidence that victims of domestic abuse are at heightened risk of harm when they separate from their abuser. This often takes the form of extreme physical violence. There does not appear to be any evidence that Ella said that she had no option other than to return to Sean, but she did tell police officers that she had attempted to leave Sean on several occasions during 2017.

- 17.23 Viewed from the perspective of coercion and control, Ella's emotions, thoughts and actions were consistent with the concept of an abused person feeling as though they are trapped within a "cage" (Stark and Hester, 2019). The cage analogy describes the social and economic inequality forced on women through coercive control. The bars of the cage symbolise an intimate partner's use of controlling tactics including psychological subjugation, strategies of violence, intimidation, isolation, humiliation, exploitation and the micromanagement of their partner's everyday life. Irrespective of whether coercive control includes physical violence, many of these tactics are rarely identified as abuse.
- 17.24 **Injuries**
- 17.25 Ella sustained several injuries. Whilst further enquiry was sometimes made about the circumstances in which the injuries were acquired, Ella often provided plausible explanations for them. Ella's alcohol consumption and a brain injury may have increased her risk of falls but it may also have increased her vulnerability to physical abuse that might result in falls. Lessons from other DHRs point to the need to look beyond immediate explanations for injuries especially when there is already of a history of domestic abuse.
- 17.26 **Was Ella's heightened vulnerability owing to her physical health considered as part of the risk assessment?**
- 17.27 It seems that in 2018 West Mercia Police were aware of Ella's heightened vulnerability. However, no actions to minimise the risk to Ella appear to have been taken, for example, to ensure that Ella had the means to call for help if necessary and to reinstate regular checks on Ella. A therapies review on 27th February 2018 suggested Ella would benefit from a "social review" or "functional assessment". There is no record of a functional or care and support needs assessment and on 12th April 2018 ASC told Housing that Ella did not have any support needs. It is not clear, therefore, whether Ella's heightened vulnerability owing to her physical health was included in any risk planning at this time.
- 17.28 **Given Ella's stroke and seizures did she have the mental capacity to make her own decisions on future living arrangements?**
- 17.29 The critical decisions that Ella needed to make about her future living arrangements were where she lived and with whom, and how her care and support needs could best be met, in order to keep herself safe. However, Ella's mental capacity to make these decisions were not considered by practitioners.
- 17.30 With the exception of a clinician in the RAID team who assessed Ella's mental capacity to be interviewed by the police, Ella was assumed to have mental capacity to make decisions. However, factors that were, or may, have been present in Ella's life, such as head injury, Korsakoff's syndrome, hepatic encephalopathy, stroke and seizures, borderline personality disorder and adverse traumatic experiences in child and

adulthood could have prompted the need for mental capacity to be considered and formally assessed.

- 17.31 It is likely that Ella's decisions about, for example, staying with Sean were based on emotions as much as they were on an analysis of facts. However, if Ella had been found to lack the capacity to make decisions it would have provided the opportunity to have made decisions in her Best Interest and if, as was likely, Ella opposed these, to instruct an Independent Mental Capacity Advocate (IMCA) to represent her and to seek determination by the Court of Protection. There is no certainty that approaches like this would have been successful, but they may have provided a way of disrupting the cycle of coercion and control, refusal of outside help, and neglect and self-neglect (Recommendation 6).
- 17.32 **How was Sean managing financially after he finished work in November 2022 – was there any evidence of economic abuse?**
- 17.33 Accommodation 12 raised concerns in 2019 that money had been taken from Ella's bank account. Further investigation revealed problems with Ella's benefits which were subsequently resolved. However, Sean knew Ella's PIN number and brought his own, rather than Ella's, bank statements when asked to assist with the investigation into Ella's account. It does not appear that the concerns about money in Ella's account were fully resolved.
- 17.34 Sean had received a lump sum from the sale of the house that he had owned with his sister, but it appears there was no knowledge of how Sean was managing financially in November 2022.
- 17.35 There was no evidence that Sean was economically abusing Ella. However, there was no follow-up into concerns that other residents of the hotel had been economically abusing Ella. Consequently, no steps were taken to protect Ella from economic abuse, to identify perpetrators or to establish if Sean had played any role in facilitating economic abuse of Ella by others.
- 17.36 **How did agencies work together to protect Ella?**
- 17.37 There are examples of agencies working together. In Ella's case, for example, the joint visit by Housing, ASC and West Mercia Police in April 2017 led to Ella's admission to hospital to receive appropriate treatment when she was very ill. However, ASC commented that there was no multi-agency meeting of all the practitioners involved with Ella and Sean. Such a meeting could have considered and initiated multi-agency interventions. MARACs were held in 2016 and 2017. Particularly points in time where further multi-agency intervention may have been helpful were when Ella's mobility and health deteriorated substantially after the empyema and stroke(s) in 2018, and when Ella and Sean refused care visits from care providers in 2022, and before Sean was to become Ella's full-time carer in November 2022.

- 17.38 ASC commented in hindsight that there appeared to be no responsibility and response to the possibility of Ella being at risk of domestic abuse. (Recommendation 7).
- 17.39 Many of the factors that may have placed Ella at higher risk of domestic abuse were present (physical disabilities, mental health needs, alcohol dependency, homelessness and housing insecurity and previous abusive relationship(s)). Consequently, Ella faced compound and multiple inequalities which not only increased her risk of being a victim of domestic abuse, but also decreased the likelihood of domestic abuse being identified and reported. It is unclear whether these factors were considered at a multi-agency level. (Recommendation 8)
- 17.40 **Other conclusions relevant to Ella, but not specifically in the original terms of reference.**
- 17.41 According to SafeLives (2019), there has been a lack of progress in integrating responses to domestic abuse within health services, resulting in a lack of support for victims and a lack of challenge to perpetrators. As a result, domestic abuse often goes undetected in mental health services and domestic abuse services are not always equipped to support people with mental health needs. SafeLives made a number of recommendations for greater recognition of the links between domestic abuse and the mental health needs of victims and perpetrators and for greater integration between health and domestic abuse services, including the use of the NICE (National Institute of Clinical Excellence) 2016 quality standards for domestic abuse recognition and response to monitor the effectiveness of health services (Recommendation 8).
- 17.42 West Mercia Police referred to Ella's "lifestyle choice" in records. However, given Ella's history of adverse childhood experiences (ACEs), alcohol dependency and history of abusive relationships, the concept of lifestyle choice might be misleading. Victims of domestic abuse with addictions, mental health issues or complex, chaotic lifestyles may be dismissed as being unreliable or even complicit in the abuse they experience.
- 17.43 Trauma-informed approaches to engaging with Ella in the context of domestic abuse and of self-neglect might have been helpful. These include flexibility of means and times of contact; using strength-based approaches that built relationships on the basis of what Ella enjoyed doing; using incentives to reward engagement; using assertive approaches rather than sign-posting and expectations that Ella would self-refer and making the most of the "window of tolerance" when Ella was most able to engage.
18. **Lessons to be learned: Learning and practice development and/ or actions already taken**
- 18.1 From Adult Social Care's perspective, it is evident that there was a lack of professional curiosity by many of the practitioners involved and what Ella said was always taken at face value, rather than explored further. There was a lack of information sharing

with other services and the risks to Ella were not identified and discussed. It is evident from reading the case history that despite Ella stating that Sean was supporting her, this was not the case. Ella's environment and presentation were visibly deteriorating at the house in Accommodation 13 but there is no evidence of any multi-disciplinary discussions or meetings to share information or concerns. Also, no consideration or response was given to the possibility of Ella being at risk of domestic abuse.

- 18.2 From Shropshire Council's perspective, there has been progress in working with partner agencies to improve the recognition of and response to self-neglect.
- 18.3 From West Mercia Police's perspective, DASH risk assessments based on the questions asked by the police officer of the victim, and the victim's answers, should always be completed irrespective of whether the victim is intoxicated. If the victim declines a DASH, the officer should document their observations and domestic abuse history of the victim and make an informed risk assessment based on this. This learning point is covered in the investigating domestic abuse training now being delivered to front line officers.
- 18.4 Police Officers should recognise when domestic abuse should be investigated (for example, when it was suggested Sean may have been the victim of domestic abuse, this should have been investigated).
- 18.5 From Shropshire Council's Housing Services perspective, to recognise the importance of face-to-face interviews and home visits to obtain the full picture of a situation. To also recognise the importance of persistence and collaboration with other agencies and departments. Support for people in temporary accommodation is now provided by in-house Shropshire Council officers. These officers work closely with Housing Options officers and use the same computer system. As a Council priority Shropshire Council is reducing the use of bed and breakfast accommodation and more of its accommodation has a regular on-site officer presence, with external agencies attending to provide support for residents.
- 18.6 As a result of this DHR, the GP practice, with which Ella was registered at the time of her death, has already changed its processes for WMAS reports. All WMAS reports which contain a 'patient to contact patient's GP' automated comment are sent to a GP for review. This approach could be applied by other GP practices.
- 18.7 From a West Midlands Ambulance Service perspective, although policy was followed, documentation of the earlier visits to Ella could have been improved. Since 2022 the ambulance service has ensured that all frontline clinicians have received safeguarding training (level 3) and since this time the quality of documentation has improved, and clinicians have a greater awareness of when to make referrals to other agencies.
- 18.8 From a Shrewsbury and Telford Hospital NHS Trust perspective, executive functioning in respect of the Mental Capacity Act should continue to be included in the Trust's training.

- 18.9 From a Midlands Partnership University Foundation Trust perspective, record keeping did not always evidence decision making and some abbreviations were used in records that were not recognised by the Trust.
- 18.10 From Shropshire Community Health NHS Trust's perspective, staff to ask patients questions about domestic abuse on admission to and discharge from community hospitals.
- 18.11 From With You's perspective more professional curiosity and working with other agencies could have been attempted.
- 18.12 From the perspective of GP Surgery E, the surgery has already implemented actions to ensure that records coming into the practice are appropriately coded so that clinical staff are alerted to all risks and safeguarding concerns.

19. Recommendations

19.1 Recommendations from Agency Individual Management Reviews

- 19.2 Shropshire Council Adult Social Care Central Team to ensure that referrals for adults who are self-neglecting are prioritised.
- 19.3 Shropshire Council Adult Social Care Central Team to ensure that the allocated practitioner for self-neglect cases is either qualified or experienced and has received training on self-neglect and different types of abuse where possible.
- 19.4 Shropshire Council Adult Social Care Central Team to ensure that practitioners are aware of and following the Keeping Adults Safe protocol and recognise the need for multi-disciplinary team meetings with other agencies.
- 19.5 Shropshire Council Adult Social Care Central Team to further raise awareness, and accountability by practitioners, of domestic abuse and how to respond to it.
- 19.6 Shropshire Council Adult Social Care Central Team to support the team to apply professional curiosity in their practice.
- 19.7 Shropshire Council Adult Social Care Central Team to ensure that practitioners complete the domestic abuse awareness training and coercive control training that is available on its eLearning platform.
- 19.8 Shropshire Council Adult Social Care Central Team to seek to have a trained domestic abuse support officer within the team.
- 19.9 West Mercia Police to ensure that a risk assessment is always completed even if the victim of domestic abuse is intoxicated.
- 19.10 Midlands Partnership University Foundation Trust to ensure that clinicians evidence decision making within their records, and to ensure that clinicians use only those abbreviations that are recognised by the Trust.

- 19.11 Shropshire Community Health NHS Trust to ensure that staff ask patients questions about abuse on admission to and discharge from community hospitals.
- 19.12 WithYou to ensure that, where appropriate, working with other agencies and professional curiosity is exercised.
- 19.13 GP Surgery E to ensure that safeguarding codes and care needs are noted from documents coming into the practice.

Appendix A

Domestic Violence Disclosure Scheme (DVDS)

Clare's Law is officially known as the Domestic Violence Disclosure Scheme (DVDS) and was introduced in 2014. The scheme was named after Clare Wood, who was murdered by her ex-boyfriend in 2009. Under the DVDS, a person can apply to the police to determine if their current or ex-partner has a history of domestic violence and is known as the "Right to Ask". If police checks confirm that a person has a history of abusive or violent behaviour, then they may decide to disclose some of that information to the person enquiring. Under the "Right to Know" part of the scheme, police may make a disclosure of their own initiative if they receive information about the violent or abusive behaviour of a person which may have an impact upon the person's partner or ex-partner. The aim of the scheme is to allow someone to make an informed decision about whether or not they wish to be in a relationship if their partner has a history of violent or abusive behaviour. New guidance currently being consulted on by the Home Office proposes that the discretionary status of information sharing by the police is changed to a mandatory process. However, under the current scheme, which was in place in 2016 when John and Laura became partners, the police have discretion to decide to reveal information about previous convictions and cautions for violent or domestic-related offences.

Appendix B

MARAC and DASH

The MARAC is a Multi-Agency Risk Assessment Conference, in which victims of domestic abuse (as defined by Part 1 Domestic Abuse Act 2021 and also including other dependants) who have been identified as being at risk of serious harm or homicide are referred to and discussed.

In Shropshire a SafeLives Multi-agency MARAC assessment and referral form which includes a DASH (Domestic Abuse, Stalking and Honour Based Violence) checklist, is used by agencies to consider the risks of domestic abuse to the victim and to identify when a case should be referred to the Multi-Agency Risk Management Conference.

In Shropshire cases are referred to the MARAC when there is a) High Visible Risk – where 'Yes' answers to the DASH checklist total 14 or above, or b) Professional Judgment – an assessment of dangerousness based on an individual practitioner's consideration (this is irrespective of the DASH score), or c) Potential Escalation - It is common practice for services to determine there is a potential for serious harm or homicide when three domestic abuse events have been identified in a 12-month period, or d) Repeat Referral - a 'repeat' is any instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC.

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Domestic Homicide Review

Shropshire Safeguarding Community
Partnership

Executive Summary Report into the death of Ella 2025

Author: Patrick Hopkinson

Date Home Office notified: 13th March 2024

Date the review was completed: 5th December 2025

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Preface

The Independent Chair and the Panel members of this Domestic Homicide Review (DHR) offer their deepest sympathy to all who have been affected by the death of Tracy and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Chair also thanks the Panel members for the professional manner in which they have conducted the Review and the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1. The Review Process

- 1.1 This summary outlines the process undertaken by the Domestic Homicide Related Death Review Panel to review the death of Ella who lived in Staffordshire. Ella had been **coerced and controlled by her partner Sean**.
- 1.2 Pseudonyms are used to protect the identities of the deceased and their family members.
- 1.3 The decision to undertake a DHR was made by Shropshire Safeguarding Community Partnership in consultation with local specialists. The Home Office was informed of this decision on 13th March 2024. IMRs were commissioned and agencies were advised to implement any learning arising from these as soon as possible. A Panel meeting to discuss the IMRs was held on 24th June 2024. An Independent Chair and author for the Review was appointed in September 2024.
- 1.4 The review was not completed within the six-month timeframe suggested by the Home Office due to the capacity of the agencies involved to participate in Domestic Homicide Review.
- 1.5 Agencies that potentially had contact with Ella or Sean were contacted and asked to confirm whether they had contact with them.

2 Contributors to the Review

2.1 Each of the following organisations submitted an IMR or information for the review.

AGENCY	CONTRIBUTION(S)
Shropshire Council Adult Social Care	Chronology and IMR
West Mercia Police	Chronology and IMR
Shropshire Recovery Partnership / With You (alcohol support)	Chronology and IMR
Shropshire Council Housing Options Team	Chronology and IMR
Midlands Partnership University NHS Foundation Trust	Chronology and IMR
GP Practice	Chronology and IMR
Shrewsbury and Telford Hospital NHS Trust (SaTH)	Chronology and IMR
West Midlands Ambulance Service	Chronology and IMR
Shropshire Community Health NHS Trust	Chronology and IMR
Department for Work and Pensions	Chronology and IMR
University Hospitals of the West Midlands (RSUH)	Chronology and IMR
Care Home and care provider	Chronology and IMR

3 Review Panel Members

3.1 The DHR panel, which met four times, consisted of the following members.

Independent Chair and Author	Patrick Hopkinson
Development Officer	Shropshire Safeguarding Community Partnership
Head of Adult Safeguarding	Shropshire and Telford & Wrekin Integrated Care Board
Service Manager for Safeguarding Adults	Shropshire Council Adult Social Care
Detective Inspector	West Mercia Police
Prevention Manager	Shropshire Fire and Rescue Service
Head of Probation	The Probation Service
Service Manager	Shropshire Recovery Partnership
Domestic Abuse Strategic Lead	Shropshire Council
Senior Housing Options Officer	Shropshire Council Housing Options Team
Head of Safeguarding	Midlands Partnership University NHS Foundation Trust
Named GP for Safeguarding	GP Practice
Head of Adult Safeguarding	Shrewsbury and Telford Hospital NHS Trust
Clinical Safeguarding Officer	West Midlands Ambulance Service
Nurse Specialist Safeguarding Adults	Shropshire Community Health NHS Trust
Head of Safeguarding	Shropshire Community Health NHS Trust

Advanced Customer Support Senior Leader	Department for Work and Pensions
Adult Safeguarding Nurse	University Hospitals of North Midlands NHS Trust
Registered Manager	Care Home and care provider
Principle Social Worker and Service Manager	Shropshire Council Children's Services

- 3.2 The panel members were not operational staff and did not have direct or indirect contact with Ella or Sean.

4 **Author of the Overview Report**

- 4.1 The Independent Chair, who is also the Author of this Overview Report, is Patrick Hopkinson, an independent adult safeguarding consultant, a Safeguarding Adults Review author and a Chair and author of Domestic Abuse Related Death Reviews.
- 4.2 The Independent Chair is experienced in adult safeguarding and provides training, including on domestic abuse, consultancy and service development services nationwide for the statutory and voluntary sectors. The Independent Chair was the Head of Adult Safeguarding for a London Borough, contributed to regional and national policy development and was the adult social services strategy lead on Violence Against Women and Girls (VAWG). The Independent Chair was a member of a Community Safety Partnership and developed practice and strategic links between domestic abuse services, adult safeguarding and the Metropolitan Police to recognise and respond to domestic abuse experienced by people with mental health needs, learning disabilities and physical disabilities. The Independent Chair has completed the Home Office online Domestic Homicide Review training and is a member of the AAFDA (Action After Fatal Domestic Abuse) network.
- 4.3 The Independent Chair is an Associate of the Local Government Association, and of Partners in Care and of Research in Practice of Adults. The independent chair is a Fellow of the Royal Society of Medicine and a Member of the British Psychological Society. The independent chair has completed the Action After Fatal Domestic Abuse Domestic Homicide Review Chairs' Certificate.
- 4.4 The Independent Chair has no connection with the Community Safety Partnership, and agencies involved in this Review other than in chairing Safeguarding Adults Reviews and Domestic Abuse Related Death Reviews.

5 Terms of Reference

5.1 Background

5.2 This Review, as commissioned by Shropshire Safeguarding Community Partnership, considers the involvement and actions of the different agencies with Ella and her partner Sean from 1st December 2017 to autumn 2023. In addition, the Review also examines past events to identify any relevant background or trail of abuse before Ella's death. By taking this holistic approach, the review seeks to identify appropriate solutions to make the future safer.

5.3 Domestic Homicide Reviews came into statute on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The review was commissioned as a domestic homicide review (DHR) under the existing guidance and criteria set out below.

5.4 The Domestic Violence, Crime and Victims Act (2004) states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a) A person to whom she was related or with whom she was or had been in an intimate relationship, or;
- b) A member of the same household as herself;

With a view to identifying the lessons to be learnt from the death.

5.5 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

5.6 The Domestic Abuse Act (2021) defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour

- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

5.7 For the definition to apply, both parties must be aged 16 or over and ‘personally connected’, which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

5.8 Controlling behaviour is defined as, *“A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour”*.

5.9 Coercive behaviour is defined as, *“An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”*

5.10 Key lines of Enquiry

5.11 The following terms of reference were agreed by the DHR panel to guide the review.

5.12 Was your agency aware that there was domestic abuse in Ella and Sean’s relationship? How did your agency respond to this and minimise the risk to Ella?

5.13 How did your agency respond to incidences of domestic abuse between Ella and Sean? Is there anything that could have been done differently?

5.14 When Ella disclosed domestic abuse how did your agency respond to hearing her voice when she said she felt she had no option other than to return?

5.15 In February 2018 Ella suffered a traumatic subdural suffered*, what is your understanding about how this occurred?

5.16 Was Ella’s heightened vulnerability owing to her physical health considered as part of the risk assessment?

- 5.17 Given Ella's stroke and seizures did she have the capacity to make her own decisions about future living arrangements.
- 5.18 How was Sean managing financially after he finished work in November 2022 – was there any evidence of economic abuse?
- 5.19 How did agencies work together to protect and safeguard Ella?
- 5.20 * In the initial stages of this Review, it was believed that Ella had suffered a traumatic subdural haematoma in 2018, but as the Review progressed it became apparent that Ella had suffered a subdural empyema instead. An empyema is caused by an infection rather than by a head injury.

5.21 Methodology

- 5.22 Twenty-two local agencies were sent an initial scoping form and asked to examine their records to identify if they had provided services or support to Ella or Sean. Ten agencies were found to have relevant information. An initial scoping meeting was held on 29th January 2024 and from this meeting the key partners made the recommendation to the Shropshire Safeguarding Community Partnership's Independent Chair that the criteria had been met for a Joint Safeguarding Adult Review and Domestic Abuse Related Death Review. The Independent Chair agreed. From the information provided at the initial scoping meeting there were a further two agencies identified that would be important contributors to the Review.
- 5.23 The key lines of enquiry were drawn up by the original independent chair and author in consultation with and agreed by the panel. A template Individual Management Report was sent to each agency involved with both Ella and Sean. The template asked agencies for a chronology of their involvement as well as to provide responses to these specific key lines of enquiry. Agencies were also asked to identify any individual learning from their exploration of involvement with Ella and Sean.
- 5.24 The Review involved the analysis of each agency's IMR, chronologies of agency contact with Ella and Sean, and questions for professionals. Family members were also interviewed by the original chair.
- 5.25 Individual Management Reports (IMRs) were written by individuals who did not work directly with Ella or Sean, and these were presented to the Review Panel, where there was opportunity for questions to be posed by panel members.
- 5.26 The Review involved the analysis of a combined and annotated multi-agency chronology of involvement, IMRs and questions for professionals. Family members were also interviewed by the Chair.

6. Summary Chronology

- 6.1 Between 2017 and 2023, when she died, Ella lived at eleven different addresses. In addition she had several stays in hospital, and twice she was of no fixed abode. Due to her home moves Ella changed GP surgeries four times.
- 6.2 Ella had a history of depression and of overdoses. Ella suffered from agoraphobia and a psychiatric report stated that she used alcohol as a coping mechanism. Ella had experienced domestic abuse from a previous partner and in 2015 Ella entered into a relationship with Sean.
- 6.3 In November 2016 Shrewsbury and Telford Hospital NHS Trust (SaTH) raised a Multi-Agency Risk Management Conference referral when Ella disclosed that she had been emotionally abused by Sean. In response, a Domestic Abuse Risk Management Plan (RMP) was created for Ella and Sean to monitor their relationship, check on their welfare and offer support to them.
- 6.4 In February 2017 Ella was found lying in the road intoxicated. Police officers recorded that Ella “had the capacity to choose and accept the risks associated with her lifestyle choice”.
- 6.5 In March 2017 Shropshire Council Housing referred Ella to Shropshire Council Adult Social Care (ASC). There were concerns that Sean was trying to control Ella. Ella appeared unwell, was self-neglecting and was living with Sean in what was described as an unsuitable property. ASC opened a safeguarding enquiry.
- 6.6 In April 2017, a member of ASC, a Housing Officer and a police officer made a joint visit to Sean’s home. Sean at first denied that Ella was at home. The ASC practitioner persuaded Sean to allow them to see Ella who was in bed, clearly unwell. Ella had difficulty communicating, had stomach pains and was very jaundiced. Ella was taken to hospital where she was treated for acute hepatitis with hepatic encephalopathy, and community acquired pneumonia with pulmonary oedema.
- 6.7 While in hospital Ella alleged she had been kidnapped and raped, and that she had experienced domestic abuse. Ella said that Sean was very controlling, would not let her see her friend, had hit her and had attempted to sexually assault her. Ella said that Sean kept her intoxicated to stop her from leaving him, which she had tried to do on several occasions. Later Ella withdrew the allegation of rape. The police did not record a separate crime report for the domestic abuse allegation and took no further action. Ella was discharged from hospital in June 2017 to a placement, but spent most of her time at Sean’s address. The safeguarding enquiry, which had been opened in March 2017, was closed in June 2017 as the risks to Ella were considered to be reduced when Ella was admitted to hospital and discharged to a placement.
- 6.8 Between June and September of 2017 there were ten reported domestic incidents between Sean and Ella. Some were reported by neighbours. Police officers were often unable to distinguish who was the perpetrator and who was the victim and usually both Ella and Sean were under the influence of alcohol. The police made DASH

assessments for most of the incidents. One incident was referred to ASC, but there is no record of it being received.

- 6.9 In October 2017 Housing sent Sean a final written warning letter for anti-social behaviour and in December 2017 the Risk Management Plan was closed by the police.
- 6.10 In February 2018, Ella was treated in for a subdural empyema (pus from an infection). Ella had suffered a stroke, which caused weakness to the left side of her body and experienced seizures.
- 6.11 After this, Ella had eight reported falls between July 2018 and August 2023. These resulted in injuries including a fractured upper arm, a broken wrist and shoulder injuries. Practitioners explored the reasons for the injuries on some occasions but found no evidence of domestic abuse.
- 6.12 In December 2018 Ella moved to an adapted bungalow with daily care visits. In January 2019 Ella cancelled her carers saying that Sean would support her and in February Ella and Sean moved to a motel. In March, ASC recorded Sean as Ella's carer.
- 6.13 In April 2019 West Midlands Ambulance Service (WMAS) raised a safeguarding concern with ASC noting that Ella was self-neglecting and that residents at the motel were taking her money and belongings. The motel manager said that Sean often locked Ella in during the day without food. As WMAS had taken Ella to hospital, SaTH followed up these matters. After making enquiries SaTH reported that it did not think there were any safeguarding concerns.
- 6.14 Ella stopped drinking in June 2019. In the autumn of 2019 Ella had two appointments with With You, (Alcohol Support service), but did not re-engage afterwards, and it is thought she later began drinking alcohol again.
- 6.15 In March 2020 Ella moved into new accommodation and was supported with daily care visits for personal care, medication, meals and drinks.
- 6.16 In April 2022 WMAS made a safeguarding referral to ASC about Ella's self-neglect, unkempt home environment and a lack of care. A Section 42 Care Act 2014 enquiry was not made as there did not appear to be any allegation of risk of on-going abuse by a third party.
- 6.17 In June 2022 Ella was discharged back home following stays in hospital and residential care. Ella was provided with daily care calls. Ella's carers were concerned about Ella's living conditions. Ella and Sean often turned carers away saying Sean was providing care.
- 6.18 In October 2022 Sean's manager called the police as Sean had not attended work. Sean's manager was concerned that there was a domestic element to Sean's absence as colleagues mentioned a video of Sean being assaulted by Ella.

- 6.19 Care agency visits stopped in November 2022 as Sean was to be Ella's full time sole carer.
- 6.20 In May and August 2023 WMAS reported information to Ella's GP intending that the GP should visit Ella. However, staff at the GP practice interpreted both reports as meaning that Ella would contact the practice for a review. Consequently, the documents were filed rather than being forwarded to a GP for action. On the second occasion the ambulance crew also made a safeguarding referral to ASC. This concerned self-neglect and the poor condition of Ella's home, which presented a health and safety hazard. Ella was lying on a broken bed with a heavily stained duvet cover and was potentially taking out of date medication.
- 6.21 In December 2023 Sean called an ambulance for Ella, who had fallen out of bed two days earlier and had been left on the floor by Sean. The ambulance crew found Ella living in squalid conditions and described Ella as being very unwell and barely conscious. The crew took Ella to hospital as an emergency because they believed her condition to be critical and then contacted West Mercia Police to report its concerns about Ella. Ella died in hospital later that day.

7. Key issues arising from the review

- 7.1 This review highlights the difficulties in identifying and responding to domestic when there is sometimes hard to distinguish between the victim and perpetrator. It also highlights the challenges of identifying and responding to domestic abuse when both the victim and perpetrator may have care needs.

8. Conclusions

- 8.1 The purpose of this review was to examine:
- 8.2 **Agency awareness of domestic abuse in Ella and Sean's relationship, responses to domestic abuse and how agencies minimised the risk to Ella.**
- 8.3 Services recognised the presence, and history, of domestic abuse in the relationship between Ella and Sean. However, Ella appears to have been unwilling to disclose domestic abuse by Sean. Disclosure of domestic abuse is known to be difficult and can put victims at risk. As a result, flexibility, support and the creation of a safe environment to enable a person to talk are necessary. One of the challenges identified in this DHR was that Sean was sometimes present or in the background when police officers attended. This may have made disclosure by Ella difficult. However, in consultations without Sean present, Ella did not generally disclose domestic abuse even when asked about her relationship with him.
- 8.4 Ella and Sean's use of alcohol may have presented a barrier to the recognition of domestic abuse. Many of the incidents reported to the police were late at night when both Ella and Sean were often under the influence of alcohol. Substance dependency

can be a barrier to both disclosure and help seeking for both domestic abuse and also for substance dependency itself.

8.5 Responses to potential domestic abuse

- 8.6 Many of the police attendances were in response to Ella and Sean arguing. No criminal offence was disclosed (apart from both being drunk and disorderly). On some occasions the police sought to separate Ella and Sean for the rest of the night. Neither Ella nor Sean would make a complaint against the other and police officers found it difficult to identify one of them as the perpetrator and the other as the victim. Ella may not have fitted the stereotype of a 'perfect victim' due to her mental health needs and alcohol use. Victims of domestic abuse with addictions, mental health issues or complex, chaotic lifestyles may be dismissed as being unreliable or even complicit in the abuse they experience.
- 8.7 Neighbours called the police in response to disturbances involving Ella and Sean. Further information may have been gathered if police officers had interviewed the neighbours. As well as seeking to stop the disturbance to neighbours, the final warning letter sent by Housing to Sean for anti-social behaviour may have been a way of disrupting any pattern of domestic abuse that had been occurring between Sean and Ella.
- 8.8 West Mercia Police made a referral to ASC, following an argument between Ella and Sean and a subsequent Domestic Abuse Triage meeting. However, there is no record that this was received. West Mercia Police is not routinely informed of the outcomes of its referrals and so did not query the absence of a follow up by ASC. There is a need for feedback from ASC to agencies that make referrals to it (Recommendation 1).
- 8.9 In April 2017, Ella alleged to hospital staff that she had been raped. Although Ella subsequently retracted the allegation of rape, she had also told police officers that she had been abused by Sean who was very controlling, had physically assaulted her and had attempted to sexually assault her. West Mercia Police did not record a separate crime report for these domestic abuse allegations, which were instead recorded within the rape allegation report. It seems that the dominant allegation of rape overshadowed the other allegations which were also serious (Recommendation 2).
- 8.10 Ella said that Sean was her carer, however there were at two reports that suggested that Sean was not helping Ella with her personal care needs. ASC engaged care agencies to help Ella with personal care and medication prompts. There were gaps in provision and Ella and Sean often turned carers away. Sean was not offered a carer's assessment and his ability and his suitability as a carer was not considered (Recommendation 3).
- 8.11 Care workers did not report any concerns about the domestic abuse of Ella by Sean. There may be barriers to care workers in recognition, reporting and intervening in domestic abuse (Recommendation 4)

- 8.12 Apart from periods in hospital and care homes or when Ella received care at home, there were no processes in place to identify any neglect of Ella for substantial periods of time.
- 8.13 West Mercia Police demonstrated good practice by completing DASH assessments even when Ella and Sean refused to answer the questions. However, DASH assessments were not made when Ella and Sean were intoxicated.
- 8.14 West Mercia Police also demonstrated good practice in 2017 by establishing a neighbour as a contact between Ella and the police. This good practice could have been extended into 2018 after Ella had moved home, experienced the subdural empyema and had subsequently developed care needs. West Mercia Police noted that the number of calls to the police reduced significantly after this point in time. Considering Ella's heightened vulnerability due to mobility difficulties, West Mercia Police might have taken further precautions such as to reinstating the Risk Management Plan (RMP) or ensuring that Ella had a means to contact the police when she needed to.
- 8.15 However in order to reinstate the RMP, further reports of abuse, or information from another agency to suggest that the risk of abuse had greatly increased, would have been required. Ella would also have needed to agree to the reinstatement of the RMP. West Mercia Police also commented that the arrangements for discharge from hospital should have included consideration of Ella's ability to contact police if needed. (Recommendation 5)
- 8.16 Ella moved home frequently, with stays in hospital and was for a time homeless and of no fixed abode. Homelessness may have had an impact on Ella's health and wellbeing. It is likely that she did not receive notification of health (neurology) appointments and consequently did not attend them.
- 8.17 **When Ella disclosed domestic abuse how did agencies respond to Ella saying she had no option other than to return to Sean?**
- 8.18 There is extensive evidence that victims of domestic abuse are at heightened risk of harm when they separate from their abuser. This often takes the form of extreme physical violence. There does not appear to be any evidence that Ella said that she had no option other than to return to Sean, but she did tell police officers that she had attempted to leave Sean on several occasions during 2017.
- 8.19 Viewed from the perspective of coercion and control, Ella's emotions, thoughts and actions were consistent with the concept of an abused person feeling as though they are trapped within a "cage". The cage analogy describes the social and economic inequality forced on women through coercive control. The bars of the cage symbolise an intimate partner's use of controlling tactics including psychological subjugation, strategies of violence, intimidation, isolation, humiliation, exploitation and the micromanagement of their partner's everyday life. Irrespective of whether coercive control includes physical violence, many of these tactics are rarely identified as abuse.

8.20 Injuries

8.21 Ella sustained several injuries and often provided plausible explanations for them. Ella's alcohol consumption and a brain injury may have increased her risk of falls but it may also have increased her vulnerability to physical abuse that might result in falls. Lessons from other DHRs point to the need to look beyond immediate explanations for injuries especially when there is already a history of domestic abuse.

8.22 Was Ella's heightened vulnerability owing to her physical health considered as part of the risk assessment?

8.23 It seems that in 2018 West Mercia Police were aware of Ella's heightened vulnerability. However, no actions to minimise the risk to Ella appear to have been taken, for example, to ensure that Ella had the means to call for help if necessary and to reinstate regular checks on Ella. A therapies review in February 2018 suggested Ella would benefit from a "social review" or "functional assessment". There is no record of a functional or care and support needs assessment and in April 2018 ASC told Housing that Ella did not have any support needs. It is not clear, therefore, whether Ella's heightened vulnerability owing to her physical health was included in any risk planning at this time.

8.24 Given Ella's stroke and seizures did she have the mental capacity to make her own decisions on future living arrangements?

8.25 The critical decisions that Ella needed to make about her future living arrangements were where she lived and with whom, and how her care and support needs could best be met, in order to keep herself safe. However, Ella's mental capacity to make these decisions were not considered by practitioners.

8.26 With the exception of a clinician who assessed Ella's mental capacity to be interviewed by the police, Ella was assumed to have mental capacity to make decisions. However, factors that were, or may, have been present in Ella's life, such as head injury, Korsakoff's syndrome, hepatic encephalopathy, stroke and seizures, borderline personality disorder and adverse traumatic experiences in child and adulthood could have prompted the need for mental capacity to be considered and formally assessed.

8.27 It is likely that Ella's decisions about, for example, staying with Sean were based on emotions as much as they were on an analysis of facts. However, if Ella had been found to lack the capacity to make decisions it would have provided the opportunity to have made decisions in her Best Interest and if, as was likely, Ella opposed these, to instruct an Independent Mental Capacity Advocate (IMCA) to represent her and to seek determination by the Court of Protection. There is no certainty that approaches like this would have been successful, but they may have provided a way of disrupting the cycle of coercion and control, refusal of outside help, and neglect and self-neglect (Recommendation 6).

8.28 How was Sean managing financially after he finished work in November 2022 – was there any evidence of economic abuse?

8.29 Concerns had been raised in 2019 that money had been taken from Ella's bank account. Further investigation revealed problems with Ella's benefits which were subsequently resolved. However, Sean knew Ella's PIN number and brought his own, rather than Ella's, bank statements when asked to assist with the investigation into Ella's account. It does not appear that the concerns about money Ella's account were fully resolved. Despite this, there was no evidence that Sean was economically abusing Ella.

8.30 How did agencies work together to protect Ella?

8.31 There are examples of agencies working together. In Ella's case, for example, the joint visit by Housing, ASC and West Mercia Police in April 2017 led to Ella's admission to hospital to receive appropriate treatment when she was very ill. However, ASC commented that there was no multi-agency meeting of all the practitioners involved with Ella and Sean. Such a meeting could have considered and initiated multi-agency interventions. Particularly points in time where multi-agency intervention may have been helpful were when Ella's mobility and health deteriorated substantially after the empyema and stroke(s) in 2018, and when Ella and Sean refused care visits from care providers in 2022, and before Sean was to become Ella's full-time carer in November 2022.

8.32 ASC commented in hindsight that there appeared to be no responsibility and response to the possibility of Ella being at risk of domestic abuse. (Recommendation 7).

8.33 Many of the factors that may have placed Ella at higher risk of domestic abuse were present (physical disabilities, mental health needs, alcohol dependency, homelessness and housing insecurity and previous abusive relationship(s)). Consequently, Ella faced compound and multiple inequalities which not only increased her risk of being a victim of domestic abuse, but also decreased the likelihood of domestic abuse being identified and reported. It is unclear whether these factors were considered at a multi-agency level. (Recommendation 8)

8.34 Other conclusions relevant to Ella, but not specifically in the original terms of reference.

8.35 According to SafeLives (2019), there has been a lack of progress in integrating responses to domestic abuse within health services, resulting in a lack of support for victims and a lack of challenge to perpetrators. As a result, domestic abuse often goes undetected in mental health services and domestic abuse services are not always equipped to support people with mental health needs. SafeLives made a number of recommendations for greater recognition of the links between domestic abuse and the mental health needs of victims and perpetrators and for greater integration between health and domestic abuse services, including the use of the NICE (National Institute of Clinical Excellence) 2016 quality standards for domestic abuse recognition and response to monitor the effectiveness of health services (Recommendation 8).

- 8.36 West Mercia Police referred to Ella's "lifestyle choice" in records. However, given Ella's history of adverse childhood experiences (ACEs), alcohol dependency and history of abusive relationships, the concept of lifestyle choice might be misleading. Victims of domestic abuse with addictions, mental health issues or complex, chaotic lifestyles may be dismissed as being unreliable or even complicit in the abuse they experience.
- 8.37 Trauma-informed approaches to engaging with Ella in the context of domestic abuse and of self-neglect might have been helpful. These include flexibility of means and times of contact; using strength-based approaches that built relationships on the basis of what Ella enjoyed doing; using incentives to reward engagement; using assertive approaches rather than sign-posting and expectations that Ella would self-refer and making the most of the "window of tolerance" when Ella was most able to engage.

9. Lessons to be learned: Learning and practice development

- 9.1 From Adult Social Care's perspective, it is evident that there was a lack of professional curiosity by many of the practitioners involved and what Ella said was always taken at face value, rather than explored further. There was a lack of information sharing with other services and the risks to Ella were not identified and discussed. It is evident from reading the case history that despite Ella stating that Sean was supporting her, this was not the case. Ella's environment and presentation were visibly deteriorating at the house in Accommodation 13 but there is no evidence of any multi-disciplinary discussions or meetings to share information or concerns. Also, no consideration or response was given to the possibility of Ella being at risk of domestic abuse.
- 9.2 From Shropshire Council's perspective, there has been progress in working with partner agencies to improve the recognition of and response to self-neglect.
- 9.3 From West Mercia Police's perspective, DASH risk assessments based on the questions asked by the police officer of the victim, and the victim's answers, should always be completed irrespective of whether the victim is intoxicated. If the victim declines a DASH, the officer should document their observations and domestic abuse history of the victim and make an informed risk assessment based on this. This learning point is covered in the investigating domestic abuse training now being delivered to front line officers.
- 9.4 Police Officers should recognise when domestic abuse should be investigated (for example, when it was suggested Sean may have been the victim of domestic abuse, this should have been investigated).
- 9.5 From Shropshire Council's Housing Services perspective, to recognise the importance of face-to-face interviews and home visits to obtain the full picture of a situation. To also recognise the importance of persistence and collaboration with other agencies and departments. Support for people in temporary accommodation is now provided by in-house Shropshire Council officers. These officers work closely with Housing Options officers and use the same computer system. As a Council priority Shropshire Council is

reducing the use of bed and breakfast accommodation and more of its accommodation has a regular on-site officer presence, with external agencies attending to provide support for residents.

- 9.6 As a result of this DHR, the GP practice, with which Ella was registered at the time of her death, has already changed its processes for WMAS reports. All WMAS reports which contain a 'patient to contact patient's GP' automated comment are sent to a GP for review. This approach could be applied by other GP practices.
- 9.7 From a West Midlands Ambulance Service perspective, although policy was followed, documentation of the earlier visits to Ella could have been improved. Since 2022 the ambulance service has ensured that all frontline clinicians have received safeguarding training (level 3) and since this time the quality of documentation has improved, and clinicians have a greater awareness of when to make referrals to other agencies.
- 9.8 From a Shrewsbury and Telford Hospital NHS Trust perspective, executive functioning in respect of the Mental Capacity Act should continue to be included in the Trust's training.
- 9.9 From a Midlands Partnership University Foundation Trust perspective, record keeping did not always evidence decision making and some abbreviations were used in records that were not recognised by the Trust.
- 9.10 From Shropshire Community Health NHS Trust's perspective, staff to ask patients questions about domestic abuse on admission to and discharge from community hospitals.
- 9.11 From With You's perspective more professional curiosity and working with other agencies could have been attempted.
- 9.12 From a Marden Medical Practice perspective, the surgery has already implemented actions to ensure that records coming into the practice are appropriately coded so that clinical staff are alerted to all risks and safeguarding concerns.

10. Recommendations

- 10.1 **Recommendation 1:** Shropshire ASC should establish a system of feedback with West Mercia Police on actions in response to safeguarding concerns and perpetrators and to lead on providing domestic abuse training.
- 10.2 **Recommendation 2:** Where in line with Home Office Crime Recording Rules, crime reports should detail each allegation separately so that further enquiries are made into separate offences even when a main offence allegation is withdrawn. Where Home Office rules require one or more crimes to be recorded on the same record, West Mercia Police should ensure that any lesser crimes are not overlooked.

- 10.3 **Recommendation 3:** Carer's assessments (s10 Care Act 2014), and referrals for support though, for example, Carer's Centres, should be offered when there are concerns about the ability of a partner to care for another.
- 10.4 **Recommendation 4:** The Shropshire Safeguarding Community Partnership should include care workers and care agencies in their awareness raising campaigns about domestic abuse.
- 10.5 **Recommendation 5:** When an adult in hospital has been identified as someone with a history of experiencing domestic abuse and is considered to have increased vulnerability to abuse on discharge due to their health needs, concerns should be referred to an appropriate specialist service, which should lead to further assessment and consideration of a risk management plan.
- 10.6 **Recommendation 6:** The Shropshire Safeguarding Community Partnership should highlight the use of mental capacity legislation and the Court of Protection as means of disrupting patterns of domestic abuse.
- 10.7 **Recommendation 7:** Concerns about domestic abuse should lead to the offer of referral to the appropriate local domestic abuse specialist service, following the local domestic abuse pathway document. Domestic abuse is also one of the ten examples of abuse and neglect set out in the Care Act 2014 Statutory Guidance and responses to domestic abuse can be coordinated through s42 safeguarding adult enquiries and processes.
- 10.8 **Recommendation 8:** The Shropshire Safeguarding Community Partnership to continue to promote awareness of the connections between physical and mental health needs, substance use, homelessness, housing instability, previous abusive relationships and domestic abuse. These factors increase vulnerability to domestic abuse at the same time as reducing help seeking and recognition of abuse. Awareness sessions for victims of domestic abuse would also be beneficial, particularly if produced in collaboration with mental health and addiction support services.

10.9 Recommendations from Agency Individual Management Reviews

- 10.10 Shropshire Council Adult Social Care Central Team to ensure that referrals for adults who are self-neglecting are prioritised.
- 10.11 Shropshire Council Adult Social Care Central Team to ensure that the allocated practitioner for self-neglect cases is either qualified or experienced and has received training on self-neglect and different types of abuse where possible.
- 10.12 Shropshire Council Adult Social Care Central Team to ensure that practitioners are aware of and following the Keeping Adults Safe protocol and recognise the need for multi-disciplinary team meetings with other agencies.
- 10.13 Shropshire Council Adult Social Care Central Team to further raise awareness, and accountability by practitioners, of domestic abuse and how to respond to it.

- 10.14 Shropshire Council Adult Social Care Central Team to support the team to apply professional curiosity in their practice.
- 10.15 Shropshire Council Adult Social Care Central Team to ensure that practitioners complete the domestic abuse awareness training and coercive control training that is available on its eLearning platform.
- 10.16 Shropshire Council Adult Social Care Central Team to seek to have a trained domestic abuse support officer within the team.
- 10.17 West Mercia Police to ensure that a risk assessment is always completed even if the victim of domestic abuse is intoxicated.
- 10.18 Midlands Partnership University Foundation Trust to ensure that clinicians evidence decision making within their records, and to ensure that clinicians use only those abbreviations that are recognised by the Trust.
- 10.19 Shropshire Community Health NHS Trust to ensure that staff ask patients questions about abuse on admission to and discharge from community hospitals.
- 10.20 WithYou to ensure that, where appropriate, working with other agencies and professional curiosity is exercised.
- 10.21 Marden Medical Practice to ensure that safeguarding codes and care needs are noted from documents coming into the practice.

Lisa Gardner
Development Officer
Shropshire Safeguarding Community Partnership
1-2 Castle Gates
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SY1 2AQ

8th September 2026

Dear Lisa,

Thank you for submitting the Domestic Homicide Review (DHR) report (Ella) for Shropshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 22nd July 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Ella (joint SAR and DHR)
COMMUNITY SAFETY PARTNERSHIP	Shopshire
DATE REVIEWED BY QA BOARD	22 July 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	<ul style="list-style-type: none"> • There was good engagement with Ella's daughter. • The analysis section is strong.
FEEDBACK FOR FUTURE DHRs	Please avoid the term 'domestic abuse in the relationship', 'domestic abuse between and 'abusive relationship' as it doesn't make clear who is doing what to who and does not centre the abuser and hold them accountable.

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	Title Page	Please add the month of death. The same feedback applies for the executive summary.
2	Contents Page	No amendments required.
3	Pen Portrait	<ul style="list-style-type: none"> • Please consider developing a pen portrait based on the meetings with Ella's daughter. There is detail at 14.11 which could be drawn on. • The same feedback applies for the executive summary.
4	Condolences	No amendments required.
5	Confidentiality and Anonymity	No amendments required.
6	Terms of Reference	Please indicate whether these were developed with Ella's family.
7	Equality and Diversity	This is a comprehensive section. At 11.24, please recognise the barriers Ella might have faced escaping abuse both as a child and as an adult as a counter to being 'less sensitive' to recognising abuse.

8	Background Information	No amendments required.
9	Combined Chronology	No amendments required.
10	Overview	No amendments required.
11	Analysis	<ul style="list-style-type: none"> Overall, there is good analysis in this section. However, some key issues are not addressed, including: <ul style="list-style-type: none"> The failure by agencies to identify a primary perpetrator (15.1). MARAC creating a joint plan, which in the context of domestic abuse, may have been dangerous (14.23). The comment that both parties should have been subject to DASH, when the police should have, instead, identified the primary perpetrator. The seemingly inconsistent conclusions where a section is given over to possible economic abuse at 16.58 and then at 16.108 it being stated that 'there was no evidence that Sean was economically abusing Ella.' At 16.111 on joint working, there is no reference to MARAC. The impact/trauma of child removal also does not feature as predominantly as would be expected in the analysis. Please review and include these areas accordingly.
12	Conclusions	Please reconsider some of the conclusions based on the points above.
13	Lessons learnt and recommendations	No amendments required.
14	Timescales	Please set out the rationale for the temporal window.
15	Involvement of family / friends / community	Please state whether Ella's daughter was given a copy of the Home Office information leaflet.
16	DHR contributors	It does not appear that an independent specialist domestic abuse service provider contributed to the review or sat on the panel. Please outline why this was the case.
17	DHR Panel	Please state the independence of the panel members.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.

20	Dissemination	<ul style="list-style-type: none"> • This section is incomplete. Please ensure the dissemination list includes the local Police and Crime Commissioner and the Domestic Abuse Commissioner. • Please also indicate whether Ella's daughter will be consulted about key dates to avoid publication and whether she will need any additional support at this time.
21	Action Plan	<ul style="list-style-type: none"> • The action plan is incomplete. Please ensure this is fully developed before publication. • Please set out where accountability for implementation of the recommendations sits.
22	<p>Has there been a request to withhold publication?</p> <p><i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i></p>	No requests to withhold publication.
23	Any other comments	